STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NJ
APPLICATION YEAR: 2006

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and certifications are available and maintained on file in the Office of the Assistant Commissioner of the Division of Family Health Services.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A public hearing is held and a draft of the report is posted on the Department's website to promote public input into the annual development of the MCH Block Grant Application and Annual Report. The public hearing was held on May 17, 2005, in Trenton to review the draft of the MCH Block Grant Application. Testimony was received from 15 individuals. A draft of the application was posted on the Department's website (www.state.nj.us/health/) four weeks prior to the public hearing. Notice of the public hearing was published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was mailed to over 300 individuals on the Division of Family Health Services mailing list. Public comments addressed the need for continuing support for the comprehensive Child Evaluation Centers, the Maternal Child Health Consortia, Adolescent Partnership grants, and the children with special health care needs (CSHCN) case management system. Providers of services to CSHCN cited barriers to providing comprehensive care such as low reimbursement rates from managed care providers, difficulty locating dental providers and increasing case loads for case managers. Input into Title V activities are encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The Maternal and Child Health block grant application and annual report, submitted annually by all states to the Maternal Child Health Bureau (MCHB), contains a wealth of information concerning State initiatives, State-supported programs, and other State-based responses designed to address their maternal and child health (MCH) needs. The Division of Family Health Services (FHS) in the New Jersey Department of Health and Senior Services (NJDHSS) produces the MCH Block Grant application and annual report and posts a draft of the document to its website to receive feedback from the maternal and child health community.

A brief overview of New Jersey is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state with 8.7 million residents, it has no single very large city. Only four municipalities have more than 100,000 residents. The State's population is projected to grow steadily, but slowly, to 8.7 million as of July 2004.

Compared to the nation as a whole, New Jersey is more racially and ethnically diverse. According to the 2002 New Jersey Population Estimates, 77.6% of the population was white, 14.5% was black, 6.3% was Asian or Pacific Islander and 1.1% reported two or more races. In terms of ethnicity, 14.2% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2002, 21.7% of mothers delivering infants in New Jersey were Hispanic, 72.4% were white, 17.5% were black, and 8% were Asian or Pacific Islanders. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDHSS. The Division of FHS, the Title V agency in New Jersey, has identified improving access to health services, reducing disparities in health outcomes and increasing cultural competency of services as three priority goals for the MCH population. Specific attention has been placed on the reduction of racial and ethnic disparities in black infant mortality, preterm births, childhood lead poisoning, obesity prevention, asthma prevention, newborn biochemical screening, reduction of risk taking behaviors among adolescents, and women's health.

To improve access to health services, the State has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs) since 1992. In SFY 2004 it was recognized that increasing access to quality preventive and primary care for the underserved and uninsured populations in New Jersey was critical. New Jersey focused efforts on building increased capacity among existing FQHCs, as well as making resources available to establish new access points in underserved communities. During state fiscal years 2004 and 2005, New Jersey has increased access to primary health care by adding ten new access points and expanding the capacity of existing centers. In SFY 2005, over $19 million will support reimbursement of uninsured primary health care visits at 20 FQHCs with over 60 sites. In SFY 2006, the Department will continue efforts to expand access by adding another ten new sites with $5 million state appropriation.

To promote access to services, children with special health care needs, who are Supplemental Security Income (SSI) recipients or previously received a waiver of mandatory enrollment into an HMO, continue to be enrolled in managed care. The Title V Program through the Birth Defects Registry is collaborating with Medicaid to identify any child who may have special health care needs but is not on SSI. This is in order to ensure that the child and their family have access to any special services that would otherwise be available to that population, including case management services.

The State's budget for fiscal year 2006 includes continued funding of the NJ FamilyCare program maintaining services and eligibility of children and pregnant women. New Jersey also has a "state-

only" program for undocumented residents who are pregnant to ensure access to prenatal care. Services may be accessed in a hospital's prenatal clinic or through a FQHC. However, health insurance alone is not sufficient to meet the ever-growing needs of New Jersey's population. Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. Title V will continue to maintain a safety net of services, especially for children with special health care needs. Even with reduced financial barriers to health care for children, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

Reduction of racial and ethnic disparities in health outcomes continues to be a priority in the Division of FHS with a focus on infant mortality and adolescent pregnancy. Many of the minority health report recommendations are being addressed by FHS, including a focus on cultural competency training. The Division of FHS was selected as one of five state Title V programs to participate in Targeted Technical Assistance. The National Center for Cultural Competence at the Georgetown University Center for Child and Human Development conducted the Technical Assistance as part of the Federal Maternal and Child Health Bureau Strategic Plan, with the objective of increasing the percentage of states that implement culturally competent policies, procedures, and practices to 100%. One of the major goals identified by the group for follow-up was the development of a statewide network. The network, named the New Jersey Statewide Network for Cultural Competence (NJSNCC), has grown from eight participating organizations and agencies to nearly 30, has appointed an Executive Committee, and has in place a listserv that notifies subscribers of meetings, training and conferences, and other matters related to cultural competence. The major activity of the NJSNCC in the past year has been the development of a Web site, which is nearly complete and ready to go on line. In addition to giving information about NJSNCC and its mission, the Web site will enable individuals to subscribe to the listserv and will provide links and references to national resources on cultural competence. Its major feature, however, will be an accessible database of statewide resources in New Jersey that provide culturally competent services to individuals and other organizations.

Both nationally and in New Jersey, obesity is a growing epidemic and public health priority. The prevention and control of obesity and other chronic diseases through nutrition and physical activity is addressed through initiatives by staff in a number of programs throughout the Department and Division including perinatal health, family planning, child and adolescent health, and senior services. Beginning in 2002, the Department of Health and Senior Services (DHSS), Child and Adolescent Health Program, has spearheaded several initiatives. In collaboration with the Department of Education (DOE), DHSS collected retrospective height and weight data of nearly 2,400, 6th grade student health records from 40 randomly selected schools of varying socioeconomic strata. The NJ Child Weight Status Report, 2003-2004 is posted on the DHSS website and presentations are being given throughout the State to make the results of this report known. DHSS and DOE are collaborating to determine the next steps for data collection.

In collaboration with Rutgers University and the New Jersey Obesity Group, The New Jersey Childhood Obesity Roundtable II took place in December 2004. This was a follow-up to the June 2002 meeting. Youth-focused nutrition and physical activity initiatives are being implemented which use pedometers as a method to motivate youth to be more active. Children are also tracking their progress through activity logs. Initiatives are being implemented through youth serving organizations and in school districts. The New Jersey Council on Physical Fitness and Sports, an advisory body created under Public Law 1999 Chapter 265 and staffed by DHSS, promotes the health of the citizens of New Jersey by developing safe, healthful and enjoyable physical fitness and sports programs. Recognizing obesity as a problem affecting all New Jerseyans, an Obesity Prevention Task Force (A3534, PL 2003, Chapter 303) held its first meeting in December 2004. The purpose of the Task Force is to study, evaluate, and develop recommendations and specific actionable measures to support and enhance obesity prevention among New Jersey residents, particularly among children and adolescents. The recommendations shall comprise the basis for a New Jersey Obesity Action Plan to be presented to the Governor within 18 months of the initial meeting.

As a project with the Healthy Child Care New Jersey (HCCNJ) grant, a PLAY (Physical Lifestyles for Active Youngsters) Task Force was established in 2003 on the recommendation of the participants of the HCCNJ Advisory Board. The purpose of the Task Force was to promote physical activity in infants, toddlers and preschool children in child care settings, to develop workshop curricula about age-appropriate play activities for implementation in child care settings, and to make recommendations to the Office of Child Care Licensing to include daily age-appropriate structured and unstructured physical activity as part of the child care program day. The Task Force has prepared two physical activity curricula, one for infants and toddlers and the other for preschool children, and presented these at several conferences.

Funding is being sought to make the PLAY curricula more available to the child care provider population in our State. An article has been written about the activities of the PLAY Task Force, and published in the Winter 2005 Edition of the Early Childhood Health Link Newsletter. PLAY Activity Cards were also included with the article, and are a regular feature of this quarterly publication that is distributed to 10,000 child care providers statewide. The nutrition component of the PLAY philosophy is being added in 2005. Members of the Task Force are exploring the possibility of collecting data from the Head Start, WIC and Medicaid populations to access height and weight information of our youngest population, and to work with child care providers to better meet the nutritional needs of the children in their care.

As follow-up to the development of the Universal Child Health Record, a companion document, a Special Needs Care Plan, has been developed as well as a training curriculum about the use and implementation of medical care plans in child care settings. The purpose of this is to better meet the health and safety needs of children in child care and to provide information and support to the caregivers of all children, and in particular to those children with special health care needs. The development of these documents has been in collaboration with the Medical Director of the HCCNJ project who has also taken on the leadership role of increasing awareness of child care issues and participation of New Jersey's pediatricians in promoting health and safety in child care environments. To that end, a curriculum entitled EPIC Child Care -- Education Physicians on the Community has been established. This program was introduced at Grand Rounds at Jersey Shore Medical Center in 2004 and another presentation is scheduled for March 2005 at Monmouth Medical Center inviting physician to schedule an educational program to their entire practice staff. Other programs are to be scheduled in Mercer and Morris counties.

Promoting healthy and safe early childhood programs has also been on the State's agenda. This past year, after receipt of the Early Childhood Comprehensive Systems grant from the Maternal and Child Health Bureau, the Division's child health program convened a planning team charged with development of an integrated approach to an early childhood support and delivery system. Working with a myriad of public and private agencies, New Jersey's challenge is to work as partners with Build NJ -- Partners for Early Learning and the National Infant Toddler Child Care initiative, two other grant supported projects with similar and complementary goals. The Healthy Child Care New Jersey project has also continued to flourish, publishing newsletters, implementing a Universal Child Health Record (UCHR) and providing ongoing educational opportunities for child care providers.

To promote adolescent health, the Community Partnership for Healthy Adolescents initiative has been established in eight communities to promote healthy behaviors and reduce high-risk behaviors in regard to sexual behavior (unintended and teen pregnancy and sexually transmitted infections including HIV), violence and injuries, nutrition and physical activity, and substance use or abuse.

In the area of newborn screening, the Newborn Biochemical Screening Program has now expanded from four disorders in early 2001 to its current twenty disorders. In March 2005, the Newborn Screening Annual Review Panel convened to assess the progress of the expanded screening program and to make recommendations for possible further expansion. The fee charged to hospitals for newborn screening services was increased to ensure adequate revenue is available to cover laboratory testing, follow up and access to vital diagnostic and medical management services. With this funding a network of treatment centers serve as a safety net to ensure that all affected children

receive critically needed follow up and treatment services.

The Office on Women's Health (OWH), in the DHSS, has been very active over the past year. The OWH successfully implemented a women and heart disease awareness campaign by supporting and coordinating with the Women's Heart Foundation in New Jersey. The second annual Women's Heart Walk is planned, and throughout the past year professional and public educational activities have been conducted. Collaboration is essential to the success of this office. To ensure ongoing communication and cooperative planning, an intradepartmental working group on women's health has been convened. The working group is comprised of representatives from all Division programs serving women. Numerous women's wellness days have been held and the Teen Esteem Program has been implemented as an alternative to the health and physical education program at Trenton Central High School for 10th grade girls. This program offers the girls nutritional education, physical activity and self-esteem building exercises, and serves as a research study through Rutgers University, Department of Nursing, where they are measuring the impact of these interventions on a number of health variables, such as weight, body mass index, and sugar levels.

Bleeding disorders are a significant and serious health issue for women, particularly during the menstrual cycle, pregnancy and childbirth, impacting quality of life, costs to the health care and public health system, particularly because of the significant lack of recognition of the problem in the professional as well as the lay public. The OWH provides support to the Governor's Task Force on Women and Bleeding Disorders, gathering information for a report to the Governor, making recommendations for policies with regard to this issue.

Nationally, 10 - 15 percent of all pregnant women experience postpartum depression (PPD) within one year of the delivery. PPD is experienced by women after delivery and also as a result of fetal deaths. There are approximately 114,000 births in New Jersey annually, which means that an estimated 11,080 to 16,620 women may suffer from postpartum depression. Acting Governor Codey, in his State of the State message, proposed to make the public and the medical profession more aware of postpartum depression as a serious behavior health issue. A Post Partum Depression Working Group was convened to develop a plan that will make the medical profession and the public aware of PPD and ensure that all women have access to appropriate behavior health services, including uninsured women.

B. AGENCY CAPACITY

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in New Jersey originates from the statutes passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A.

26:2-119, 26:2-111 and 26:2H5); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. Seq,); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program (Title 26:2-130-137); and the SIDS Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following is a description of New Jersey's Title V capacity to provide preventive and primary care services for pregnant women, mothers and infants, preventive and primary care services for children, and services for CSHCN.

III. B. 1. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal, Child and Community Health Service (MCCH) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. Reproductive and Perinatal Health Services, within MCCH, coordinates a regionalized system of care of mothers and children through the six Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC. The MCHC regional plans now include pediatric need assessments and an inventory of resources including directories of providers.

The eight funded Healthy Mothers, Healthy Babies (HMHB) Coalitions continue to reduce infant morbidity and mortality through outreach and education. The HMHB Coalitions act as the Community Action Teams for Fetal Infant Mortality Review (FIMR) project.

In the Central New Jersey Maternal and Child Health Consortia (MCHC) through maternal interviews they were able to identify gaps in services as well as knowledge of such issues as fetal movement. The Central New Jersey MCHC is currently in the process of launching the "HAVE YOU FELT YOUR BABY MOVE TODAY" campaign. This initiative involves providers as well as consumer components. Additionally, the "My Prenatal Care Card" Initiative has been launched region wide. The initiative was also a featured component of the New Jersey Fetal Infant Mortality Review (FIMR) Program Poster session at the National FIMR Conference held in Washington, DC in August.

The Regional Perinatal Consortium of Monmouth and Ocean's FIMR Case Review Team also found "lack of fetal movement awareness" and lack of maternal action an educational issue. The action plan included creating and mass distributing bookmark-sized education tools entitled "Did Your Baby Kick today?" to all OB practices and prenatal clinics in the area.

The HMHB Coalitions all provide formal and informal outreach worker training. Training topics include: immunizations, personal safety, lead screening, domestic violence, child growth and development, dental health, AIDS, asthma, smoking cessation, BIMR, cultural competency, home safety, car safety, fatherhood, postpartum depression, mental health, stress reduction, addictions, parenting and other topics identified by the outreach workers.

Outreach activities range from door to door canvassing to large community events. The HMHB Coalitions sponsor community events such as Baby Showers, Baby Safety Showers, "Pregnant Pause" and Health Fairs; school based events such as the "Game of Life" and Teen Awareness Days and presentations for community groups and faith-based initiatives. Outreach efforts are also conducted wherever women gather such as grocery stores, hair and nail salons, laundromats and clinics.

HMHB Coalition activities include the hiring of multicultural, multilingual staff and the recognition of changes in existing client bases. The New Brunswick Coalition has seen an increase in the Mexican

population, the Paterson Coalition an increase in the Arab population and the Camden Coalition in the Latino population. Religious affiliations are also changing with increases in the Muslim and Hindi populations. In addition to cultural changes the family unit is also changing - increased single-father households, increased multiple births, increased adolescent pregnancies and an increase in grandparents raising grandchildren. The Coalitions are responding by attempting to increase Coalition membership from these groups. Professional and consumer education is also being expanded to include the unique needs of the population. The Healthy Mothers Healthy Babies Coalition of Jersey City awards subgrants to community-based organizations that demonstrate the capability to provide grassroots outreach and education that link vulnerable populations to community-based health care services. The Coalition is currently funding the Women Reaching Women program. This initiative targets African American women in the neighborhoods that have been identified as having the highest risk of poor health outcomes, specifically among women of childbearing age. Through intensive outreach efforts, the Women Reaching Women program brings pregnant women into early prenatal care; through education the program promotes prevention and positive health choices. The program conducts comprehensive sexuality education in middle and high schools and provides cultural competence training for the County's health care providers and community based agencies.

Perinatal Addiction Prevention Services are also part of the Reproductive and Perinatal Health Services Program. Professional and patient education is offered regarding the effects of using alcohol, drugs and tobacco during pregnancy as well as implementation of a standardized screening tool.

III. B. 2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCCH, focuses on preventive initiatives in the areas of lead poisoning, injury and violence prevention, risk reduction, oral health, nutrition and physical activity. Special emphasis has been placed on outreach and education of health care providers and the public, to ensure the screening of children under six years of age for lead poisoning. Home visiting activities continue through the Prevention Oriented System for Child Health (POrSCHe) program. Oral health education through a variety of age appropriate activities is provided to school age children through support of regional programs. The weekly fluoride mouth rinse program, "Save Our Smiles" is targeted towards high-risk children in areas that do not have fluoridated water. There are on-going planning efforts to address early childhood comprehensive systems, comprehensive school health, and health and safety issues in child care facilities. The Adolescent Health section continues to work on reduction of adolescent pregnancy, sexually transmitted infections including HIV, intentional and unintentional injuries and violence, substance use/abuse, and improved nutrition and activity. The MCCH unit continues to be very active in NJ FamilyCare outreach and enrollment activities.

The POrSCHe home visiting program is a comprehensive prevention-oriented outreach and case management system that focuses on low income, high risk families with children six years of age or younger. Eleven sites throughout the State receive funding through this program to assess blood lead levels, immunization status, nutritional status, growth and developmental milestones, and parental-child interaction and then provide education and supportive guidance as required. In 2004 a computerized data management program was initiated to assist in evaluating the effectiveness of the program and a uniform assessment process was developed.

The goal of the POrSCHe program for 2005 is to promote a coordinated support system for families through the development of stronger linkages with the Medicaid HMOs, DYFS, the Community Partnerships, Special Child Services, the Department of Education, and other community agencies providing early childhood services. Only through a coordinated effort by all these entities will the intensive case management needs of these families be addressed and preventive health strategies initiated.

Child Care Health Consultant Coordinators (CCHCCs) are located in the county resource and referral agencies statewide and are supported by Child Care Development Block Grant funds. In addition to

providing on-site consultation, a broad range of health and safety topics are provided to child care providers, parents and children.

Representatives of the CCHCCs and the HCCNJ Project Director participated in the Region II Forum, "Enhancing Partnerships: A Regional Forum on Head Start and Oral Health" held in New York City in fall 2004. The purpose of the forum was "to determine how organizations and agencies at a regional level can work together to improve oral health of Head Start children and their families". The important principles about oral health in Head Start translate well to the population of children and their families in all child care settings.

III. B. 3. Preventive and Primary Care for Children with Special Health Care Needs

Special Child, Health and Early Intervention Services (SCHEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family-centered care. A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. SCHEIS receives monthly printouts from the Social Security Disability Determination Unit that identify all children applying for Social Security Insurance (SSI). Copies of the printouts are sent to the appropriate County Case Management Units. County Case Management Units outreach to all SSI applicants to offer information, referral, and case management services. In addition, Individual Service Plans that address the medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the child and/or family are developed. Periodic monitoring of needs and progress toward attaining services are also conducted.

Although not directly supported by Title V funds, a statewide family service network providing comprehensive medical and social services to women, infants, children and adolescents for children and their families affected by HIV are also administered within SCHEIS. This network, consisting of seven sites, has enabled service to over 4,400 clients in 2004. In addition, during this past year, enrollment of 136 children, 62 adolescents and adult women, and 5 men into clinical trials has been facilitated through network operations. Through Robert Wood Johnson Medical School, the Network employs a Community Liaison to publicize the Network, provide education related to HIV disease management for consumers and providers, and provide linkages for clients to ancillary services.

SCHEIS works with parent groups, specialty providers and a statewide network of case managers to provide family-centered, community-based, coordinated care for Children with Special Health Care Needs (CSHCN) and facilitate the development of community-based services for such children and their families. The Statewide Parent Advocacy Network (SPAN) funded through SCHEIS provides parent support through a three-pronged approach titled Family WRAP (Wisdom, Resources, Advocacy and Parent-to-Parent). Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey.

SCHEIS attended the Champions for Progress Meeting in April of 2004. The meeting was sponsored by HRSA and the University of Utah. The purpose of the meeting was to gather information on how Title V agencies across the varied states work cooperatively with their Medicaid counter parts and their parent networks. The meeting was attended by a resource parent from SPAN and a representative from Medicaid Managed Care, as well as a nurse consultant from SCHEIS. An opportunity was offered to apply for a project grant. SCHEIS case management offered technical assistance to SPAN to apply for this stipend. SPAN has received the grant and will use the monies to enhance adolescent children's transition to adulthood. Representatives from SCHEIS Case Management and Specialized Pediatric Services participate on the SPAN Champions Center Incentive Award titled Transition from Youth to Adult Services within a Culturally Competent Medical Home for Youth with Disabilities or Special Health Care Needs, providing technical assistance and support, and liaison between the Champions and MCH Block activities.

Project Care, in existence since 1986, provides statewide family support by fourteen paid parents of CSHCN housed in 11 County Case Management Units. In addition, financial support through Project

Care partially subsidized the annual SPAN conference for CSHCN. In SFY 2004, nearly 500 families attended the 2-day SPAN conference. SCHEIS staff provided information on case management, New Jersey FamilyCare, newborn biochemical and hearing screening, Early Intervention Services, and other programs and services for CSHCN. Parent support is also provided through the Parent-to-Parent program.

Parent-to-Parent is a telephone support service that matches trained volunteer support parents with other parents of children who have similar health care needs. Nearly 81 support parents were trained in SFY 2004 and 174 matches were made.

The third program within Family WRAP, Family Voices New Jersey (FVNJ), focuses on education, advocacy, medical home, and expanded outreach to families of CSHCN. The New Jersey Coordinators of FVNJ provided training and technical assistance in the first 9 months of SFY 2004 to approximately 12,000 parents and professionals. A brochure describing Family WRAP is provided to each family served through the county case management units.

SCHEIS and SPAN have successfully collaborated to apply for supplemental funding for Family WRAP activities from local philanthropic organizations including the Essex Healthcare Foundation targeting Essex County and the Van Houten Foundation targeting Bergen and Passaic efforts, and the Health Resources Services Administration's Early Hearing Detection Intervention (EHDI) project. In FY 2004 Family WRAP's involvement with New Jersey's EHDI project included: targeted outreach to parents, organizations, and agencies that provided family support to children who are deaf or hard of hearing; training of 8 volunteer support parents of children that are deaf and/or hard of hearing; and development of a flyer (in English and Spanish) to educate parents about newborn hearing screening follow-up. Expanded cultural competency efforts include recruiting support parents among the Chinese and Haitian/Creole communities to organize focus groups and enhance outreach efforts.

C. ORGANIZATIONAL STRUCTURE

The organizational structure of the New Jersey Title V program has not changed since the submission of the FFY 2002 application. All Maternal and Child Health (MCH) programs including programs for Children with Special Health Care Needs (CSHCN) continue to be organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Celeste Andriot Wood, Assistant Commissioner, Division of FHS.

D. OTHER MCH CAPACITY

Maternal and Child Health Epidemiology Program

The Maternal and Child Health Epidemiology Program (MCH Epi) is under the direction of Lakota Kruse, M.D., M.P.H., Medical Director for the Division of Family Health Services. The Office of the Medical Director provides medical and epidemiological consultation for all the division's programs. The mission of MCH Epi is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects.

The MCH Epi Program promotes the central collection, integration and analysis of MCH data. Ingrid Morton is the Program Manager for MCH Epi, which is comprised of four research professionals, and two support staff. All research staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant.

Maternal, Child and Community Health

MCCH is comprised of two program managers, 39 professionals, and 24 support staff. All staff members are housed in the central office. Dr. Linda Jones-Hicks became the Service Director for MCCH in January 2004. Dr. Jones-Hicks is a pediatrician with specialty training in Adolescent Medicine and experience with several MCH coalitions in New Jersey. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds. MCCH has four major programs: Perinatal Services, Reproductive Health, Child and Adolescent Health and the Children's Oral Health Education Program.

Reproductive and Perinatal Health Services is staffed by 15 professionals and six support personnel and a Program Manager, Sandra Schwarz. The program is responsible for the regional MCH Consortia, Healthy Mothers/Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Healthy Start projects, the HealthStart comprehensive maternity services, Family Planning, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, and preconceptual health. Resources for staff have been from Federal MCH Block, Federal Title X, and Healthy Start Grants.

The Child and Adolescent Health Program is comprised of a staff of 13 professionals, 9 support personnel and a Program Manager. Resources for staff have been from State, Federal MCH Block Grant, Preventive Health and Health Services Block Grant and Centers for Disease Control and Prevention grants. All staff members are housed in the central office. Child and Adolescent Health is divided into early childhood and adolescent health sections. The early childhood section has a coordinator and eight professionals the Project Director for the Healthy Child Care New Jersey Project and New Jersey's Early Childhood Comprehensive Systems grant is included in the early childhood section. The adolescent health section includes school health and abstinence education and is headed by a coordinator with a staff of four professionals. Child and Adolescent Health staff have varied professional backgrounds including nursing, nutrition, family counseling, health education, environmental health, and research and data analysis.

The Children's Oral Health Education Program comprised of 1 professional and 1 support staff report to the Office of the Director. Dr. Beverly Kupiec coordinates the program which provides age appropriate oral health education to school age children.

Special Child, Health, and Early Intervention Services (SCHEIS)

Special Child, Health, and Early Intervention Services (SCHEIS) consists of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, Child and Adult Special Services, and Early Intervention Services. Gloria Rodriguez is the Director of SCHEIS. All SCHEIS staff members are housed in the central office. Early Intervention Services is headed by Terry Harrison. This program provides services to infants and toddlers with disabilities or developmental delays in accordance with Part C of the Individuals with Disabilities Education Act.

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), Early Hearing Detection and Intervention, the New Jersey Center for Birth Defects Research and Prevention and the National Down Syndrome Study. The EIM Program is comprised of a staff of ten professionals, seven support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has over 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and two Centers for Disease Control and Prevention cooperative agreements. An additional 4 year CDC cooperative agreement was awarded to the EIM Program in September 2003. This funding will be utilized to enhance data linkage and exchange between the SCHS Registry and the Family Centered Care Program.

The Newborn Screening and Genetic Services Program is responsible for the follow-up of all newborns having been identified with abnormal screening results. This program is also responsible for the oversight and administration of several specialty care centers for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is comprised of a staff of 9 professionals, three support staff and a Program Manager, Mary R. Mickles. Ms. Mickles is a Registered Dietitian, holds a master's of Science degree in Nutritional Science and has extensive experience in management and public health. Resources for staff as well as specialized pediatric treatment programs are provided through an Inborn Error of Metabolism Laboratory fee and state designated appropriation. Dr. Tajwar Aamir pediatric consultant was appointed as the Chief Medical Consultant to Special Child Health and Early Intervention Services on May 4, 2004.

The Family Centered Care Program (FCCS) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded case management units, Family WRAP family support services, 11 child evaluation centers, 5 cleft lip/cleft palate centers, 3 tertiary care centers, and the 7 Ryan White Title IV funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Title IV. This program is comprised of a staff of seven professionals, three support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Bonnie Teman, RN, MSN.

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

E. STATE AGENCY COORDINATION

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. Specific programs include the activities of eight Healthy Mothers/Healthy Babies Coalitions, Perinatal Addictions Prevention Projects, preconceptional health counseling, regional Childhood Lead Poisoning Prevention Coalitions, and facilitation of the Black Infant Mortality Reduction initiative. These activities have continued to expand during the reporting period and have gained the attention of other department programs.

A representative from Reproductive and Perinatal Health Services serves as the liaison to two of the New Jersey Healthy Start Projects (Camden and Trenton) and is responsible for the collaboration and coordination of the New Jersey Healthy Start Projects with Department activities and programs. This collaboration will help to assure integration of services and the effective use of both State and Healthy Start funds to eliminate disparities in women's and infant's health. The Camden project is funded through the Southern New Jersey Perinatal Cooperative and the Trenton project is funded through the City of Trenton Department of Health. The Atlantic City project was funded through August 2004.

The DHSS has a seat on the Child Fatality and Near Fatality Review Board (CFNFRB), which is in, but not of, the Department of Human Services, Division of Youth and Family Services. Staff from Reproductive and Perinatal Health Services represents the Commissioner of Health and Senior Services on this board. A major outcome of the relationship with the CFNFRB is to work towards a coordinated effort of mortality/morbidity review in New Jersey.

Staff from Reproductive and Perinatal Health Services participates in the Steering committee for Promoting Safe and Stable Families (Title IV-B) within the Department of Human Services. Efforts continue to enhance and increase the community-based delivery of family-preservation, family support, time-limited family re-unification and adoption promotion and support services. The DHSS has a seat on the Governor's Council on Alcoholism and Drug Abuse.

The Perinatal Addiction Prevention Project address prevention of Fetal Alcohol Spectrum Disorders (FASD) through screening, education and treatment. Through the Office of Prevention of Mental Retardation and Developmental Disabilities (OPMRDD), the Fetal Alcohol Syndrome (FAS) Task Force was convened to assess and make recommendations regarding FAS prevention.

In SFY 2002, state funds became available for establishment of prevention, diagnosis and treatment centers for Fetal Alcohol Syndrome (FAS). In SFY 2003, $450,000 was again awarded to SCHEIS, Specialized Pediatric Services, to continue the Centers of Excellence for diagnosis, treatment, and education. With these funds, four child evaluation centers (2 are multi-agency collaborative projects), continue to function as centers of excellence and in FY 2003, one center also received a CDC regional centers grant to develop a core curriculum to be used nationwide to educate health care professionals on FAS. The staff of the Centers are in contact with the FAS Task Force, the MCH Consortia, the Department of Education, The ARC, and other state and community agencies who serve the FAS community. Additional funds in the amount of $400,000 were awarded to the Reproductive and Perinatal Health Services for the Perinatal Addictions Prevention Coordination project through the MCH Consortia. This program provides for professional and community education regarding the use and abuse of alcohol, drugs and tobacco during pregnancy. This regional approach reaches both the public and private sector providers of care to ensure access to risk reduction assessment and intervention.

A function of the FAS Centers is to provide FAS community based outreach and education for the public and providers. Audiences targeted for outreach and education included Department of Human Services Division of Youth and Family Services, schools, parent-teacher organizations, Head Start, medical grand rounds and radio public service announcements. The Centers also developed and maintain an education and resource based web site, www.fasnj.org, which is in its second year of operation.

Teen pregnancy prevention is at the forefront in New Jersey. The Advisory Council on Adolescent Pregnancy Prevention held its first meeting in April 1999. The Council is in, but not of, the Department of Health and Senior Services. Representation includes designees from the Departments of Human Services, Education, Community Affairs, and Labor. Some of the Council's responsibilities include development of policy proposals, promoting a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and promoting community input and communication. The Council has established working groups on data, male involvement, school-based services and teen parenting. In 2003, the Council developed a three-year strategic plan to guide the work of the Council and focus on specific areas of interest. In 2005 a report to the Governor and Legislature on Council activities will be published.

The WorkFirst Teen Pregnancy Prevention Work Group is another example of successful interdepartmental collaboration. The Department of Human Services serves as lead agency for this initiative and the group has been charged with planning, developing and implementing new initiatives. Using TANF grant funds, $1.1 million was allocated for Teen Pregnancy Prevention Initiatives. Youth-to-youth programs and mentoring projects are now underway and a Teen Pregnancy Resource Center has been established. MCCH staff participate along with representatives of the Departments of Human Services and Education. MCCH also has the responsibility for the State's Abstinence Only Program.

More emphasis is also being placed on facilitating health and safety in child care settings. Collaboration between the DHSS and the New Jersey Department of Human Services, Division of

Family Development over the past four years has resulted in the establishment of an infrastructure to promote the health and development of young children in childcare settings. A position for a health consultant nurse has been created in the childcare coordinating agencies in every county. Nurses from local health departments and other community agencies are being trained to be health consultants to their local child care providers. Staff from the two Departments collaborated with the State chapter of the American Academy of Pediatrics in obtaining a Federal Healthy Child Care America Grant to support this initiative.

The collaboration between DHSS and the New Jersey Department of Human Services includes not only the Division of Family Development but also the Office of Child Care licensing. Staff from both Divisions actively participate on the HCCNJ Executive Board, the PLAY Task Force, the Medication in Child Care and Communicable Disease Committees, and the team members of the Early Childhood Comprehensive System Planning Grant. Of particular benefit of the collaboration with the Office of Child Care Licensing has been the ability to make recommendations based on the National Health and Safety Performance Standards for Out-of-Home Child Care Programs that have strengthened child care regulations in New Jersey concerning health and safety issues. The annual Health in Child Care Conference in May 2005 will feature Kevin Ryan, the Child Care advocate for New Jersey.

Training of health professionals as child care health consultants continues with over 150 public health nurses from local health departments completing the four-day training. The first meeting of the Public Health Practice Standards Task Force for Infants and Preschool Children was convened on February 23, 2005. Members of that Task Force include representatives from public health nursing, county Child Care Health Consultants Coordinators, child care resource and referral agencies, health officers, child care center and family child care providers, Head Start, New Jersey State Nurses Association, New Jersey Society of Public Health Educators and parents.

In January 2004 the DHSS initiated a process to develop an Early Childhood Comprehensive Systems (ECCS) Plan for New Jersey. This planning process is supported by a federal State Early Childhood Comprehensive Systems grant. Partners with DHSS on the ECCS Planning Team include the New Jersey departments of Human Services, Education, Community Affairs, Environmental Protection, and Labor, and the Juvenile Justice Commission. Community partners include the Association for Children of New Jersey, the Youth Consultation Service, Healthy Child Care New Jersey, Children's Futures, and the University of Medicine and Dentistry of New Jersey. The Planning Team also includes three parent members. To facilitate the process, the ECCS team is collaborating with an existing statewide program, the BUILD New Jersey Partners for Early Learning initiative.

The Children's Oral Health Education Program works with a variety of collaborating partners on oral health education age appropriate activities. The DHSS maintains a Memorandum of Agreement (MOA) with the University of Medicine and Dentistry-NJ Dental School for the provision of dental health consultative services to the Program. Arnold Rosenheck, D.M.D., Assistant Dean at UMDNJ continues to serve as dental consultant. The DHSS was a collaborating partner in the planning of the 2005 Oral Health Summit with the New Jersey Oral Health Coalition held on April 27, 2005.

School health collaboration and coordination is accomplished through a school health liaison position within the Adolescent Health Section. The Departments of Education and DHSS staff have developed joint statements and a Strategic Plan for School Age Health signed by both Commissioners. The strategic plan affirms both departments' support for comprehensive school health programs, with a particular focus on the 31 special needs school districts.

In February 2005, an intradepartmental meeting was held to build relationships and improve intradepartmental communication; identifying existing resources (programs/services) so that a "Resource Guide to School Health Programs" can be developed; identify a plan for marketing the adoption of the Coordinated School Health Program (CSHP) model across all State Departments; and strengthen the joint statement between the Departments by establishing an interdepartmental memorandum of understanding (MOU) that would outline the roles and responsibilities of each Department. The intent of the MOU would be to institutionalize a CSHP within the current structure of

the New Jersey state government. In other words, create infrastructure capacity for a CSHP.

Another collaborative training, sponsored by federal partners including the Association of Maternal and Child Health Programs (AMCHP), took place in January 2005 with five designees, from the DHSS and the Department of Education, on "Strengthening State and Education Agency Partnerships to Improve HIV, STD and Unintended and Teen Pregnancy Prevention in Schools". As a result of attendance at this training, New Jersey's draft vision statement is "To create and maintain a collaborative infrastructure that maximizes resources and results in more assessable and effective sexual health programs (including health services) for youth". In the next 6 months, the New Jersey team plans to: 1) contact and invite School-Based Youth Service Programs and Family Planning to join the State team; and 2) DHSS/DOE to share in scheduling and planning 2 meeting between February and June 2005 to discuss funding sources/budget, grant priorities, objectives, projects and activities.

The Community Partnership for Healthy Adolescents (CPHA) are coordinating with the Office on Local Health's Community Health Partnerships. The Community Health Partnerships are being implemented in each New Jersey County with funding from the CDC and NACCHO. The funding supports a team that includes a planner, public health partnership coordinator, health educator/"risk communicator", public health nurse, information technology person, secretary, and perhaps, a part-time medical director. The Community Health Partnerships were established in the fall of 2004 and by spring of 2005, they are expected to be implementing MAPP (Mobilizing for Action through Planning and Partnerships) where information and data will be collected for a comprehensive needs assessment. By collaborating with this group, the CPHA can provide input and advocate on behalf of adolescents to assure that the needs of this population are not overlooked or minimized.

The injury prevention specialist in the Child and Adolescent Health Program participates in the Northeast Injury Prevention Network, a collaborative of the six New England states, New York, and New Jersey. Activities in the past year have focused on suicide prevention, including producing a suicide data book covering the eight states, and suicide prevention plans for each of the states.

Coordination between the State's Primary Care Association and Federally Qualified Health Centers continues. In 2005, a new Office of Primary Care was created. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office.

The Perinatal and Pediatric Care Task Force was convened in November 2004 by the Deputy Commissioner, Health Care Quality and Oversight with the Center for State Health Policy at Rutgers University serving as staff. The Assistant Commissioner, Family Health Services and the Program Manager, Reproductive and Perinatal Health Services are serving as consultants to the Task Force. Membership of the Task Force includes individuals recommended by the MCH Consortia Boards of Trustees and other interested constituencies. Two Consortia Directors are serving as members of the Task Force.

Special Child Health and Early Intervention Services (SCHEIS) and the Statewide Parent Advocacy Network (SPAN) continue to collaborate to improve services to CSHCN, including transition to adulthood services. The Essex County SPAN Resource Specialist, (parent of a CSHCN) initiated a pilot project on transition to adulthood. A transition to adulthood information packet template evolved from the pilot project. County specific resources are incorporated to include local resources, and the packet is given to youth served through the SCHEIS case management units.

To assist families of children with special needs in navigating the Medicaid Managed Care system a Medicaid Managed Care Alliance was formed in October 1999. This alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCHEIS case managers and others. The Medicaid Managed Care Alliance continues to meet approximately annually. It promotes collaboration between HMO case managers and the County Case Management Unit staff which has proven valuable in problem solving access to appropriate

specialized pediatric services, payments for non-covered medical and or social services for CSHCN, and smoother transition between systems of care such as Early Intervention, Medicaid model waivers, and special education. In October 2002, Medicaid Managed Care Alliance members were invited to participate in a meeting focusing on the reorganization of SCHEIS services and ongoing efforts to achieving community based systems of care for CSHCN and their families. This meeting successfully linked SCHEIS state staff and grantees with parents, Medicaid HMO case managers and the Department of Human Services Quality Assurance and Monitoring staff, and led to closer working relationships at the county and provider agency level. This cooperative relationship continues between the county case management units, the Medicaid HMO case mangers and the DHS Quality Assurance and Monitoring staff. Likewise, it has facilitated dialogue between the specialized pediatric services' providers and families in easing access to pediatric specialty care.

During Year 2002, the Reproductive and Perinatal Health Services reorganized the Folic Acid Coalition of New Jersey with 29 members representing the Department of Health and Senior Services (DHSS), March of Dimes, Department of Human Services, Maternal and Child Health (MCH) Consortia and others. In addition, the Program filed an application for the Folic Acid Coalition of New Jersey membership to the National Council on Folic Acid on December 27, 2002, that has been approved. Based on the membership, the DHSS has been receiving electronic updates, as well as folic acid resources, from the National Council on Folic Acid that are shared with the Coalition membership, the MCH Consortia, the Family Health Line, Center for Family Services, Inc., and other agencies on a quarterly basis.

In May 2001, SCHEIS partnered with the Department of Human Services, Division of Deaf and Hard of Hearing (DDHH) and the MCH Consortia to conduct three, one-day training seminars for newborn hearing screening. The training conferences conducted by national experts in hearing screening, provided guidance and hands-on training for hospital staff, physicians, and audiologists on the new rules and screening equipment. In January 2002, new legislation was enacted to strengthen the mandate to universally screen all newborns for hearing loss.

SCHEIS has a seat on the Division of the Deaf and Hard of Hearing's (DDHH) Advisory Council. EIM Staff and staff from the DDHH have implemented quarterly meetings in order to coordinate and implement activities to strengthen the Early Hearing Detection and Intervention Program.

In October 2004, SCHEIS partnered with the New Jersey Hospital Association to present to staff from NJ, hospital information concerning updates to newborn screening. Also, a video was created describing the importance of bringing babies who failed their hearing or blood spot screen back for repeat screens. This video is closed-captioned and is available in Spanish and English.

The "Children's System of Care" initiative has been initiated in three (3) counties, which will be a new system of comprehensive services for children with mental illness or severe emotional and behavioral problems. State funds of $39 million have been committed to create this centralized system. SCHEIS staff both welcome and anticipate collaborative efforts regarding this initiative. Currently, SCHEIS staff is represented on the Community Mental Health Board and Planning Council.

Through the activities of the New Jersey Center for Birth Defects Research and Prevention, staff from Special Child Health and Early Intervention are building collaborative relationships with numerous agencies in New Jersey, such as the University of Medicine and Dentistry in New Jersey (Newark and New Brunswick facilities), the New Jersey School of Public Health, the Children's Hospital of New Jersey at Newark Beth Israel Medical Center, the Environmental and Occupational Health Sciences Institute, Rutgers University, and the NJDHSS Division of AIDS. Additionally, Centers' staff has developed a strong network with the other ten national Centers and other researchers. The focus of the collaborations has been to improve the surveillance of birth defects and to initiate a variety of research projects to further the understanding of the causes of birth defects. Among the funded projects is the formation of a fetal abnormality registry, which will document the occurrence of birth defects among pregnancies as opposed to live births. This data is critical for calculating accurate rates of the occurrence of birth defects, including better information on the evaluation of the impact of

folic acid on pregnancies affected by neural tube defects. Other examples of local research projects are a study of hypercoagulability study and the investigation of the role of endocrine disruptors on the occurrence of hypospadias.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Prior guidance for the MCH Block Grant specified a set of "core health status" indicators, which were required to be reported each year. Many States have used most of the core health status indicators to monitor their progress in improving or maintaining their primary care infrastructure. These "core health status" indicators (formerly core health status indicators #1, #2, #3, #6, #7 and #8) and one developmental health status indicator (#4) are now referred to as "health systems capacity" indicators. These "health systems capacity" indicators will be reported annually under the new guidance.

#1 HSCI - The rate of children hospitalized for asthma (10,000 children < 5)

DHSS is a member of the Pediatric/Adult Asthma Coalition of New Jersey (PAC/NJ). PAC/NJ is organized by the American Lung Association of New Jersey and the New Jersey Thoracic Society. It has developed a Strategic Plan to address asthma in New Jersey, and has formed six task forces to develop and implement activities to achieve the objectives of the Plan.

Significant accomplishments to date include establishment of a PAC/NJ website, toll free number, and fact sheet; the development of a model Asthma Action Plan form and accompanying educational brochure; dissemination of the 38,000 copies of the Asthma Action Plan to schools; development of the "Stepwise Approach to Asthma Management," a single-page summary for physicians of the NHLBI Guidelines for asthma care; distribution of the summary to pediatricians, family practice physicians, and emergency room physicians along with the "Asthma Action Plan;" broadcasting of a training program that reached 248 school nurses; packaging and distribution of a video tape of the broadcast and other educational materials in a resource kit for school nurses, distribution of 189 "Health Hop -- Asthma Stuff" CD's to school nurses; development and pilot testing of a classroom video which is to be distributed to schools; development of a public information card on the "Top Ten Things You Can Do to Reduce Asthma Triggers in the Home," distribution of 10,000 "Top Ten…" cards to schools and 14,500 cards through Eckerd Pharmacies, DHHS staff participate on the Steering Committee of the Coalition, as well as on the School, Child Care, Education, and Health Insurance task forces.

At the invitation of the Institute of Medicine, Division of the National Academies of Science, PACNJ sent a four member team, including a DHSS representative, to the Crossing the Quality Chasm Summit in Washington in January 2004. PACNJ was one of four asthma projects from across the nation invited to participate in the summit.

A grant from CDC has been used to create a surveillance position in the MCH Epidemiology Program. The Research Scientist has developed a database on asthma mortality and hospitalizations, using data from the Vital Statistics and Hospital Discharge reporting databases. Information from the database was used to develop an annual summary report on "Asthma in New Jersey". This data is also made available to the PAC/NJ task forces for planning and evaluation purposes. Due to an increase in federal funding level, two additional asthma positions will add to the Division of Family Health Services' Chronic Disease program. With additional staff, asthma infrastructure and program planning and implementation will be enhanced.

In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group prepared a strategic plan for the activities of New Jersey State Government in addressing asthma.

The New Jersey Special Child Health Services Registry allows for the voluntary reporting of asthma as a chronic condition in children. Children registered are referred to the Family Centered Care

Program, which provides case management assistance to the families through the county-based Special Child Health Services case management programs.

The Child Care Committee of PAC/NJ set as a priority for 2004 the development of a tool kit for child care providers concerning asthma management in child care settings. This was supported by a competitive grant awarded to the American Lung Association from Aetna. The tool kit included the production of a bilingual video of care management to support the educational curriculum and handout materials for child care providers and parents. The educational program was piloted in three counties in the fall of 2004, and pilot train-the-trainer was presented to 47 participants, primarily nurses, at the Annual Child Care Health Consultation Conference held on November 30, 2004. A new grant application has been submitted to make the training materials available to child care providers statewide. The new application will also strengthen the environmental aspects of the educational curriculum.

#2 HSCI - The percent Medicaid enrollees whose age is < 1 year who received at least one initial periodic screen.

Medicaid in New Jersey is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in Medicaid.

One of the major focuses of the Prevention Oriented System for Child Health (POrSCHe) initiative is to promote proper use of preventive health services by the families of children at high risk of preventable health and developmental problems. POrSCHe nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or New Jersey FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are POrSCHe projects in 11 communities.

#03 HSCI - The % State Children's Health Insurance Program (SCHIP) enrollees whose age is < 1 year who received at least one periodic screen.

New Jersey FamilyCare is New Jersey's SCHIP. It is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare.

One of the major focuses of the Prevention Oriented System for Child Health (POrSCHe) initiative is to promote proper use of preventive health services by the families of children at high risk of preventable health and developmental problems. POrSCHe nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or New Jersey FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are POrSCHe projects in 11 communities.

#04 HSCI - The % of women (15 - 44) with a live birth whose observed to expected prenatal visits are >= 80 % on the Kotelchuck Index.

The Healthy Mothers, Healthy Babies (HM/HB) Coalitions promote early prenatal care utilization through outreach and education. Outreach efforts include door-to-door canvassing of neighborhoods, presentations at community events and the availability of outreach workers where pregnant women may gather such as food stores, hair and nail salons and laundromats. Outreach workers have been trained to educate pregnant women on the importance of early prenatal care and to connect them to prenatal care services. Educational efforts include formal presentations to community groups,

organizations and faith based initiatives on the importance of early prenatal care. Education is also provided to health care providers to eliminate barriers to early prenatal care including cultural sensitivity, the need for multi-lingual multi-cultural staff and the need for family friendly office space and scheduling.

#05 HSCI - Comparison of health indicators for Medicaid, non-Medicaid, and all populations in the State

The BIMR, HM/HB, FIMR, FAS, Perinatal Addictions and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM/HB Coalitions (NPM #18) are designed to improve birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions projects (SP #9) educate providers and consumers on the effects of substance abuse on LBW, infant mortality and prenatal care. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants (NPM #15).

#06 HSCI - The % of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants, children, and pregnant women.

The Medicaid Program in New Jersey is located in the Department of Human Services. Pregnant women with incomes below 185% of the Federal Poverty Level are eligible for Medicaid Health Start comprehensive maternity services. The comprehensive services include medical care, case coordination, health education and psychological services.

#07 HSCI - The % of EPSDT eligible children aged 6 - 9 years who have received any dental services during the year.

Based upon 2004 data, a total of 31,823 (33.9%) eligible 6 - 9 year old children received dental services during 2004 out of 93,858 children eligible for EPSDT services. Dental initiatives undertaken to promote utilization of dental services are:
- MD Education Regarding Dental Referrals - EPSDT Screenings: A letter was sent to all Medicaid/NJ FamilyCare Primary Care Physicians (General Practice, Family Practice, Internal Medicine, Pediatricians) and Nurse Practitioners (Family, Pediatrics, Community Health, School Health) enlisting their help in the eradication of childhood dental disease by performing a dental inspection during the EPSDT physical examination and making referrals to a dentist within the timeframes recommended by the Medicaid/NJ FamilyCare program or whenever dental disease is identified.
- Oral Health Stuffer: A stuffer, aimed at increasing utilization of dental services by educating beneficiaries and/or parent/caretakers about the importance of good oral health and the relationship to good overall health, was developed and distributed to Medicaid/NJ FamilyCare families.
- Quarterly Dental Director's Meetings: Office of Quality Assurance conducts quarterly meetings with the HMO dental directors to discuss quality issues including EPSDT.
- Annual Report of EPSDT Performance Measures: The Office of Quality Assurance contracts with the Peer Review Organization of New Jersey to conduct an annual study of HMO EPSDT performance.
- HMO Annual Assessment: DMAHS conducts annual assessments of HMO performance, which includes questions in the dental element regarding measures taken to improve utilization of dental services for EPSDT eligibles.

#08 HSCI - The % of State SSI beneficiaries < 16 receiving rehabilitation services from the State CSHCN Program.

SCHEIS continues to ensure that Supplemental Security Income (SSI) beneficiaries less than 16

years old received rehabilitation services. Although SCHEIS does not provide direct rehabilitative services to SSI beneficiaries, the program does provide the outreach and case management services to ensure that SSI beneficiaries receive these necessary services. In New Jersey, SSI beneficiaries who meet family income guidelines are eligible for comprehensive Medicaid benefits, which include the rehabilitative services of audiology, physical, occupational, and speech therapy. All New Jersey children applying for SSI disability are referred by the State SCHEIS office to the County Case Management Units through a letter of agreement with New Jersey Department of Labor, Disability Determinations.

In 2004, approximately 3100 SSI beneficiaries less than 16 years old will have had an Individual Service Plan including rehabilitative services developed for them by the County Case Management Units. Approximately 25% of the children in active case management caseload are SSI recipients. In an effort to improve outreach to SSI beneficiaries, the Department has modified the database forwarded by Disability Determinations to access beneficiary's telephone numbers. It is anticipated that this additional information will improve outreach efforts and result in an increase in SSI beneficiaries served.

#09A HSCI - The ability of States to assure Maternal and Child Health to policy and program relevant data/information.

The goals of the State Systems Development Initiative (SSDI) grant within the MCH Epidemiology Program focus on Health Status Indicator (CHSI) #9A for building data capacity in MCH. The first goal of the grant focuses on improving linkages of MCH datasets and the second goal of the grant focuses on improving access to MCH related information. Linking MCH related datasets is important to the needs assessment process for communities and the evaluation of program services. Assuring access of FHS to MCH related datasets is important to improving the reporting of Title V MCH Block Grant Performance/Outcome Measures and to improving the delivery of services to the MCH population.

Our vital statistics files, Medicaid files and programmatic data files all provide some information about the status of health in the MCH population and the effectiveness of MCH programs. However, no file alone provides the full picture of what happens to pregnant women, infants and children. In order to accurately assess the continuum of events that lead to favorable or unfavorable outcomes, files and information systems should be linked.

MCH Epi has been able to both link records across files and longitudinally across health care related events in a mother's life. A combined dataset was created for the years 1996 through 2002 containing the electronic birth certificate, mother and newborn hospital discharge records, and infant death certificates for all NJ births. Data from this dataset are used to support research projects that focus on welfare reform and immigrant health, foreign-born mothers and issues related to health disparities, and maternal mortality review in New Jersey.

Six years of asthma-related hospital discharge data have been longitudinally linked to create a wealth of information surrounding hospitalizations for children with asthma. This dataset is being used to enhance our asthma surveillance system as well as examine issues related to repeat admissions, and asthma severity.

The MCH Epidemiology Program with CDC funding has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey in collaboration with the Center for Public Health Interest Polling at Rutgers University. Additional funding was obtained from the Division of Additions within the NJDHSS to include questions concerning maternal smoking. Data from this survey will be used to identify pregnancy risks and to develop international and programmatic interventions.

#09B HSCI - The ability of States to determine the percent of adolescents in grades 9 - 12 who report using tobacco products in the past month.

The New Jersey Youth Tobacco Survey (YTS), based on a model developed by CDC, is administered

by the DHSS Division of Addiction Services. This bi-annual survey is administered to a sample of students in grades seven through twelve. The 2001 YTS report is available at www.state.nj.us/health/as/yts/. Current use of any tobacco (defined as any tobacco use on one or more days in the 30 days preceding the survey) for among high school students significantly declined from 38.9% in 1999 to 26.8% in 2004. The YRBS also collects information on adolescent smoking, but is not as focused and extensive on tobacco use as the YTS.

#09C HSCI - The ability of States to determine the percent of children who are obese or overweight.

The 2003 New Jersey Student Health Survey (NJSHS) of high school students incorporates much of the Youth Risk Behavior Survey (YRBS), which is one component of the Youth Risk Behavior Surveillance System developed by the CDC and includes the collection of self-reported data on height and weight. The NJSHS is administered by the New Jersey Department of Education (DOE) with significant support from the DHSS. The 2003 NJSHS indicate 9% of students were overweight (>= 95th percentile for Body Mass Index (BMI) by age and sex). However, another 12% of high school students were found to be "at risk" for overweight (85th to 95th percentile BMI).

A working group from DHSS, DOE, and the Department of Law and Public Safety met to address newly required active parental consent for students to participate in surveys at school and concerns about adequate return rates for the YRBS and other school surveys. They developed a New Jersey School Survey (NJSS), which includes the height and weight elements of the YRBS and combines core elements of the YRBS, Youth Tobacco Survey, and the Attorney General's survey on drug use. A middle school version of the NJSS was also developed.

In June 2002, the Deputy Commissioner of DHSS convened the New Jersey Childhood Obesity Roundtable to bring nearly 50 stakeholders together to generate recommendations for preventing or reducing childhood obesity in the state. Roundtable participants learned that public school nurses regularly collect student height and weight data; however, this information has not been accessible for evaluation at the state level. Thus, one of the recommendations of the Roundtable was to "collect baseline and ongoing anthropometric data" for the purpose of guiding state policy, program planning and evaluation of nutrition and physical activity initiatives.

At the New Jersey Action for Healthy Kids Summit in May 2003, DHSS announced its commitment to conduct a retrospective review of student health records for the collection of height and weight data. This survey would help to establish a baseline estimate of weight status in New Jersey youth. The pilot was completed in collaboration with the Department of Education (DOE) and the results were announced during a Governor's press conference in September 2004. A sampling of 2,393 school health records of 6th grade students from 40 randomly selected schools of varying socio-economic strata, indicated 38% of students were at risk for overweight (20%) or overweight (18%). This exceeds the national figure. Presentations are taking place throughout the State to inform organizations and individuals of the results of the NJ Child Weight Status Report, 2003-2004. A short and long report is posted on the DHSS web site. DHSS and DOE will be collaborating to determine next steps for data collection.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 Maternal Child Health Bureau (MCHB) has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section describes the performance reporting requirements of the Federal-State partnership. Figure 3, "Title V Block Grant Performance Measurement System" on the next page, presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five-year Statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities, as measured by 18 National performances measures and State performance measures should have a collective contributory effect to positively impact a set of 6 national outcome measures for the Title V population.

B. STATE PRIORITIES

SP #1. Reduction of Adolescent Risk Taking Behaviors

The Reduction of Adolescent Risk Taking Behaviors relates to National Performance Measures #8, 10, 13, 16 and State Performance Measures #5, 6 and 10. DHSS currently funds 8 Community Partnerships for Healthy Adolescents (CPHA) in 7 counties. In 1998, 9 grantees were selected through a competitive process to develop Community Partnerships. Each of the grantees has an Adolescent Health Plan for its adolescent target group and has implemented activities since July 1, 2003.

The goal of these Partnerships is for local health departments, community-based organizations, schools, and health care providers to coordinate and collaborate on programs and activities that reduce risk-taking behaviors and promote healthy behaviors among adolescents. Each Partnership's activities are based on a local needs assessment that prioritized the adolescent health issues in that community. An Adolescent Health Plan is developed by a network of stakeholders to comprehensively address these issues. DHSS guidelines encourage the Partnerships to address sexual behaviors (unintended pregnancy, and sexually transmitted infections including HIV), injury and violence, nutrition and physical activity and substance use/abuse.

The Community Partnerships for Healthy Adolescents function through an established infrastructure of which consists of youth-serving stakeholders and youth. The interventions implemented by the Partnerships incorporate youth asset development and utilize "best practices" or "model" programs. Approximately 22,000 adolescents, 10-17 years old, are served annually.

SP #2. Reducing Black Infant Mortality

Reducing Black Infant Mortality is a state priority related to National Performance Measures #15, 17 and 18 and State Performance Measures #1 and 3. During the reporting period there has been significant activity to address Outcome Measure # 2, reducing black infant mortality, and State Performance Measure #1, reduction of the percent of black preterm births. The Black Infant Mortality Reduction Advisory Council has assisted the Department in several new and exciting initiatives. The public awareness campaign Black Infants Better Survival (BIBS) was the culmination of a concerted effort on the part of the Department in response to recommendations of the Blue Ribbon Panel Report

and the Advisory Councils priority interests. The campaign was unveiled in May 1999, and ran for two years. The public awareness and community education components of the campaign were targeted to get information out to black women of childbearing age and their families concerning the increased risk and strategies to improve pregnancy outcomes. A third component, professional education, targets health care providers to increase awareness, provide current data, dispel myths, suggest strategies for intervention, and discuss the impact of cultural competency on black infant mortality.

The Northern New Jersey MCH Consortium has been funded to serve as the Black Infant Mortality Reduction (BIMR) Resource Center under the Black Infant Mortality Reduction Initiative since July 1999. The Center is designed to provide technical support to programs and information to professionals with an interest in improving maternal and infant health in black families. In the summer of 2004, Dr. Linda Jones-Hicks and Ilise Zimmerman were invited to the federal Department of Health and Human Services in Washington, D.C. to present New Jersey's Approach to reducing the high incidence of Black infant death. The Division of Clinical Quality invited Dr. Jones Hicks and Ms. Zimmerman to join an Expert Panel focusing on perinatal health disparities, which would be meeting in September.

As a fourth component, seven health service grants addressing black infant mortality reduction, totaling one million dollars have been awarded to health service agencies and grassroot organizations statewide. The agencies that were awarded these grants and their activities are described as follows:

Ad House, previously funded through federal Healthy Start funds as A Healthy Start for Essex County provides an expansion of Healthy Start outreach services. Services at the agency include outreach and health education, case coordination, linkages/referrals for other services and transportation.

The Central New Jersey MCHC was funded to provide increased prenatal case finding, public health nursing visitation, linkage, and referral. Prevention education addresses preconceptional, prenatal, and postpartum health care.

The East Orange Department of Health, Infants, Mothers, and Families Division, provides prenatal case finding through community outreach. Case management and mentoring services for clients are provided by the public health nursing division and trained volunteers

The Heureka Center, Burlington County, provides community outreach and mentoring services. Community health education targets prenatal and pediatric populations in Burlington County.

The Hudson Perinatal Consortium provides risk and stress reduction, positive prenatal practices and parenting skills during the provision of prenatal services throughout Hudson County. Clients are recruited through intensive prenatal community outreach and canvassing with case coordination for health and social service needs.

The Northern New Jersey Maternal and Child Health Consortium, provides individual and group stress reduction counseling to prenatal women as an intervention in reducing the incidence of preterm labor and low birth weight births.

The City of Trenton, Division of Health, provides extensive community outreach, canvassing and interagency case coordination, with volunteer client mentoring services. These services are expansion of peer mentoring services provided by partnering agencies.

SP #3. Reducing Teen Pregnancy

Teen pregnancy prevention is a state priority for New Jersey and relates to National Performance Measures #8 (reduction of births to teens 15-17 years of age) and State Performance Measures #4 (percent of repeat pregnancies among adolescents 15-19 years of age).

The Advisory Council on Adolescent Pregnancy Prevention was established in April 1999 to develop

policy proposals, to promote a coordinated and comprehensive approach to the problems of adolescent pregnancy and parenting, and to promote community input and communication. In 2003, the Council developed a three-year strategic plan to guide the work of the Council and focus on specific areas of interest. The WorkFirst Teen Pregnancy Prevention Work Group lead by the Department of Human Services has been charged with planning, developing and implementing new initiatives. Youth-to-youth programs and mentoring projects and a Teen Pregnancy Resource Center have been established.

The Department of Human Services, the Department of Education, the Department of Labor and the Juvenile Justice Commission have collaborated with NJDHSS on the development of statewide County Collaborative Coalitions relative to teen pregnancy prevention activities. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month (May).

SP #4. Increasing Healthy Births

Increasing Healthy Births is a state priority that encompasses National Performance Measures #8, 15, 17, 18 and State Performance Measures #1, 3, 5, 8, 9. Several initiatives in the Reproductive and Perinatal Health Services address healthy births including Healthy Mothers, Healthy Babies Coalition outreach activities, Healthy Start outreach activities, and Community Action Team projects based on FIMR findings. The Perinatal Addictions Prevention projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period. Preconceptual health projects seek to have a healthy mother prior to conception.

SP #5. Improving Nutrition and Physical Activity

Improving Nutrition and Physical Activity is a state priority related to State Performance Measures # 10 and the New Health System Capacity Indicator #9. DHSS funds three Community Partnership for Healthy Adolescents to address this priority.

In 1999, State law established the New Jersey Council on Fitness and Sports, which is in, but not of, the DHSS. The Council promotes the health and wellness of New Jersey citizens by developing safe and enjoyable recreational and sports activities and programs. DHSS provides staff support to the Council. In 2004, DHSS provided funding to two professional organizations - the New Jersey Society for Public Health Education (NJ SOPHE) and the New Jersey Association for Health, Physical Education, Recreation and Dance (AHPERD) - to support pilot projects implementing recommendations of the Council. It is also funding one community-based organization in Trenton to promote nutrition and physical activity for the Trenton community.

Currently, New Jersey SOPHE coordinated the New Jersey Childhood Obesity Roundtable II, held on December 14, 2004, in collaboration with Rutgers State University, the New Jersey Obesity Group and DHSS. The agenda highlights included a presentation on the current state of childhood obesity by national speaker, Barbara Moore, Ph.D., of Shape Up America!; ten panel presentations on state and local efforts currently in place, and concluding with a consensus from the group on next steps. Roundtable recommendations/next steps will be shared with the recently legislated New Jersey Obesity Prevention Task Force. The New Jersey Obesity Prevention Task Force is a 27 member, Governor-appointed Task Force charged with the responsibility to study, evaluate and develop recommendations and specific actionable measures to support and enhance obesity prevention among New Jersey residents, particularly children and adolescents.

In addition, NJ SOPHE has been instrumental in getting the KidStrong (Inside & Out), grades 5 & 6 osteoporosis curriculum, revised in consultation with the NJ Interagency Council on Osteoporosis (ICO) Education sub-committee. A marketing plan for KidStrong and the follow-up Jump Start Your Bones grades 7 & 8 curriculum is also being developed in consultation with the ICO Education sub-committee.

New Jersey AHPERD has made pedometer school kits available to elementary and high schools. In addition, 3 bike safety programs were held with one recreation program for 1st -- 3rd graders, 4th -- 6th graders and 7th --10th graders. Physical education teachers, teaching in the same geographic area as the recreation program, were instructed on integrating bike safety into the school curriculum.

In February 2004, an application was approved for Isles, a Trenton-based, non-profit organization to promote nutrition and physical activity with Trenton youth. This grantee:
- implemented community gardens at 4 school sites,
- conducted Wacky Gym fitness activities for Trenton Moves,
- conducted after-school programs at 7 Trenton sites,
- implemented a 5 week summer program for 350 youth ages 6-12), and
- conducted nutrition classes at Trenton Central High School West and Isles YouthBuild programs.

DHSS, represented by staff from Adolescent Health, participates in the Action for Healthy Kids (AFHK) -- New Jersey State Team and on the Governor's Healthy Choices, Healthy Kids initiative. Six regional Train-the-Trainer programs were implemented by AFHK-NJ to provide training on nutrition and physical activity to school personnel. A comprehensive resource guide was distributed. In addition, AFHK-NJ has presented information regarding AFHK's national, state, and local initiatives at various schools, conferences, and seminars.

SP #6. Decrease Asthma Hospitalizations

Decreasing hospitalizations for asthma is related to National Performance Measures #7, 13 and State Performance Measures #6 and 14. DHSS is a member of the Pediatric/Adult Asthma Coalition of New Jersey (PAC/NJ). The American Lung Association of New Jersey and the New Jersey Thoracic Society organize PAC/NJ. It has developed a Strategic Plan to address asthma in New Jersey, and has formed six task forces to develop and implement activities to achieve the objectives of the Plan. Significant accomplishments to date include the development of a model Asthma Action Plan form, a single-page summary for physicians of the NHLBI Guidelines for asthma care, training program and video for school nurses and classroom staff, and a public information sheet.

In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group prepared a strategic plan for the activities of New Jersey State Government in addressing asthma.

SP #7. Improving and Integrating Information Systems

The MCH Epidemiology Program, the Division of Family Health Services, and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to National Performance Measures #1, 9, 12 and Health System Capacity Indicator #5, 9A, 9B, and 9C. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

SP #8. Improving Access to Quality Care for CSHCN

New Jersey will continue to enhance current efforts to improve access to quality of care for CSHCN, as well as provide additional training opportunities for families, case managers, Part C service coordinators and staff of the Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Care Centers, and Ryan White Title IV Family Centered HIV grantees in resources and services to support CSHCN in the community. Training will be provided to promote effective involvement of youth and parents in school to work transition, and medical transition to adulthood for the SSI population.

Information, referral, development of an individualized service plan (ISP) and ongoing monitoring to achieve identified needs for CSHCN remains a priority of Family Centered Care grantees. These

needs include medical/dental, developmental, rehabilitation, education, socio-economic, and emotional. Parent and professional training on accessing comprehensive services for CSHCN through Medicaid Managed Care, updates on changes in NJ FamilyCare, and access to community based services for CSHCN were conducted in 2004, through quarterly case management meetings, Family Centered HIV programs and collaboration on the development of conferences conducted by community based organizations such as the NJ SSI Alliance, SPAN, and the ARC of New Jersey. Likewise, Family Centered Care Services staff provides ongoing technical assistance to grantees regarding access to care issues.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		100	100	100	100
Annual Indicator		100.0	100.0	100.0	99.6
Numerator		112886	111950	113215	111583
Denominator		112886	111950	113215	112051
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2004

The number of initial newborn biochemical screenings as reported by the state's Inborn Errors of Metabolism laboratory. The number of live births ocurring in New Jersey regardless of mother's state residency according to the Electronic Birth Certificate as of 4/15/2005. In previous years the number of initial screenings exceeds the number of newborns due to difficulties in removing duplicate screens for the same child, out of state births tested in NJ or older non-newborns being screened. The software prevents the input of a numerator exceeding a denominator.

All newborns with confirmed biochemical disorders receive appropriate follow-up as detailed on Form 6.

a. Last Year's Accomplishments

The Newborn Biochemical Screening Follow-up Program, located within Special Child Health and Early Intervention Services (SCHEIS) ensures that babies with abnormal results from screening receive timely confirmatory testing, follow-up care and management. The goal is to arrange for confirmation, initiation of diagnosis, and treatment within nationally established time lines as applicable.

As of October 2003, screenings were provided for fourteen disorders; currently, newborns receive screening for twenty disorders: phenyketonuria, hypothyroidism, galatosemia, the hemoglobinopathies, including sickle cell disease, maple syrup urine disease, cystic fibrosis, biotinidase deficiency, congenital adrenal hyperplasia, medium chain acyl-CoA dehydrogenase deficiency, short chain acyl-CoA dehydrogenase deficiency, long chain acyl-CoA dehydrogenase deficiency, very long chain acyl-CoA dehydrogenase deficiency, citrullinemia, argininosuccinic academia, methylmaloonic acidemia, propionic acidemia, glutaric acidemia Type I, isovaleric acidemia, 3-hydroxy-3-methylglutaryl CoA lyase deficiency and 3-methylcrotonyl-CoA carboxylase deficiency. Support for treatment services and specialized formula has also significantly expanded to include four regional metabolic centers, 3 cystic fibrosis care centers, 5 pediatric endocrine specialty care centers, 2 biochemical genetics laboratories and 5 sickle cell treatment centers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded screenings to include 20 newborn biochemical disorders			X	
2. Tandem mass spectrometry technology has been implemented in the Inborn Errors of Metabolism Lab			X	
3. Regional specialty care centers have been established and supported for affected babies and their families	X			X
4. Ongoing collaboration with specialists and general primary care providers				X
5. FHS and Public Health and Environmental Lab staff regularly meet with established specialty consultants			X	X
6. Newborn Screening Annual Review Committee (NSARC) reconvened to advise Newborn Biochemical Screening Program				X
7.				
8.				
9.				
10.				

b. Current Activities

Currently, newborns are screened for twenty disorders listed above. In 2002, SCHEIS began funding for the establishment and provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, and specialty laboratory services. Needs for these services are due to the increase in numbers of children being identified with biochemical disorders through newborn screening.

c. Plan for the Coming Year

Testing, reporting and follow-up for the additional screening tests will continue to be directly managed by the State and available statewide. As genetic tests are perfected, it will be possible to screen for more newborn biochemical disorders. Since there are no national standards concerning which disorders to include in a screening panel, states are faced with balancing the new technologies into the system of newborn screening. More than just laboratory tests, the system must be able to follow, treat, and influence clinical outcomes. To address these changes and concerns, a Newborn Screening Annual Review Committee will be reconvened and will serve to advise the Newborn Biochemical Screening Program.

For each of the newborn biochemical disorders, quarterly meetings are held with the respective consultant groups. These groups are comprised of a wide range of medical specialists and other health care providers involved in the diagnosis and management of the disorders. The purpose of the consultant meeting is to ensure that testing and follow-up procedures used by the State are reflective of best medical and laboratory practices. Additionally, the medical consultants represent the concerns of families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate pediatric consultants, and identification of other unmet needs.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			57	58	59
Annual Indicator			57.7	57.7	57.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	61	62	62	63

Notes - 2004

The data reported in 2003 and 2004 are pre-populated with the 2002 data from the State estimates from SLAITS.

a. Last Year's Accomplishments

SCHEIS continues to support through a health service grant with the Statewide Parents Advocacy Network (SPAN) the a Parent-to-Parent Network to further increase the degree to which the State ensures family participation in program and policy activities of the State CSHCN program. The Parent-to-Parent Network links parents of CSHCN to "veteran" parents of children with similar needs for support, information on the disability, and problem solving.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			

	DHC	ES	PBS	IB
1. SPAN				X
2. Parent-to-Parent Network				X
3. Statewide Family Voices chapter				X
4. Family Satisfaction Survey to be done by the 21 county case management units				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The training and matching of parents through the Parent-to-Parent Network continues during the current year. 2004 supplemental funding from the EHDI program provided resources to conduct a targeted training of Spanish speaking only families of children that are deaf and hard of hearing, in addition to ongoing support of parents of CSHCN with more generalized needs for support. To date 800 support parents have been trained and nearly 835 matches have been made.

c. Plan for the Coming Year

Projections for FFY 2006 estimate an additional 120 parents will be trained and 180 matches made. The Statewide Family Voices Chapter, initiated by SCHEIS in collaboration with Family Voices and SPAN, will continue conducting family leadership development trainings. These trainings provide families with the information and support they need to advocate for their own children, advocate for and support other families, and advocate for improvements in policies, practices, and systems. In addition, Case Management and Specialized Pediatric Services staff will collaborate, provide technical assistance and serve on the SPAN Champions for Progress Advisory Board. The Advisory Board will target medical home and transition to adulthood, and develop a "Road Map" to assist families and CSHCN in planning and decision making. This tool is anticipated to be presented to CSHCN, families and providers at the 2006 SPAN conference and distributed to families through SCHEIS grantees.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			52	53	54
Annual Indicator			52	52	52

Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	56	57	57	58

Notes - 2004

The data reported in 2003 and 2004 are pre-populated with the 2002 data from the State estimates from SLAITS.

a. Last Year's Accomplishments

SCHEIS continues to provide enabling services to children with special health care needs (CSHCN) in order to ensure a "medical/health home" (National Performance Measure #3). SCHEIS has promoted the concept of a "medical home" as defined by the American Academy of Pediatrics through case management services, collaboration with the Statewide Parent Advocacy Network (SPAN), and support of the Child and Adult Special Services Program providers. In 2004, SCHEIS State staff conducted a statewide review of Individual Service Plans for children receiving Special Child Health Services case management to determine status of insurance and whether a primary care physician was identified. Of the 320 charts sampled, 96% documented a form of health coverage (approximately 50% Medicaid and 50% private 4% uninsured), and 94% identified a primary care provider. Those without insurance had been screened for eligibility and/or referred for SSI, NJ KidCare, and/or Medicaid. Also, children without a documented primary care provider had been referred for follow-up through Federally Qualified Health Centers, local health department and/or hospital clinics, as well as referral to pediatricians that may be accepting clients without insurance. This informal survey indicated that the majority of children served through the Case Management Units have access to both health care and a primary care provider; however, access to a medical home remains a challenge for some children. This survey will be repeated in 2005 and extended to include additional Family Centered Care Services providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Case Management Services		**X**		
2. Your Voice Counts				**X**
3. Medicaid Managed Care Alliances				**X**
4. Subsidized Direct Specialty and Subspecialty Services	**X**	**X**		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To assist families in accessing the Medicaid managed care system, SCHEIS County Case Managers continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. In an effort to assist families of CSHCN in navigating the Medicaid managed care system, a Medicaid Managed Care Alliance was formed in October 1999. This Alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCHEIS case managers and others. A brochure entitled "Finding Your Way through Medicaid Managed Care…For Families with Children with Special Needs," was developed through this initiative, and continues to be distributed statewide. In 2004, resources listing both managed care case managers and county case management unit staff were revised and distributed among staff members of both systems. Periodic case conferencing continues as needed. In the Pediatric HIV Family Centered Care Network, each of the Network agencies has entered into linkage agreements with the managed care systems operating within their catchment areas.

SCHEIS continues to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: eleven Child Evaluation Centers (CEC), five Cleft Palate Centers, three Tertiary Centers, six Genetic Centers, four Hemophilia Centers and five Sickle Cell Centers. These centers provide a comprehensive array of services with a multidisciplinary approach to assure that CSHCN receive coordinated, ongoing, comprehensive care within a medical home. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN. Approximately 42,000 children received services within the specialty network for the first time during 2004. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs. The Sickle Cell and Hemophilia programs currently focus on implementing transition activities as pediatric aged patients approach adolescence and adulthood.

In 2004 the Child Evaluation Centers organized a formal Federation whose primary goal is to advocate for children with developmental, behavioral and learning disabilities through the promotion of community awareness, collaboration of like organizations, promotion of quality care and education, facilitation of collaborative research and communication with public and private agencies. The CEC Federation developed a brochure promoting comprehensive child evaluations for distribution to families, child study teams, legislators and others engaged in the care and treatment of CSHCN.

c. Plan for the Coming Year

To assist families in accessing the Medicaid managed care system, SCHEIS County Case Managers will continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. Approximately 11,500 children are newly referred to the Special Child Health Services (SCHS) County Case Management Units each year, and all are offered case management/care coordination including the development of Individual Service Plans (ISP) that address assessment of and need for comprehensive health, education, social, and rehabilitative services. Included in the ISPs are enabling services such as transportation, economic assistance, service linkages, respite care, and general support in terms of rights and safeguards. Case managers work with these families and their physicians to ensure care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate.

In the Pediatric HIV Family Centered Care Network, each of the Network agencies has linkage agreements with the managed care systems operating within their catchment areas. These agreements will ensure the delivery of coordinated primary and specialty care for the HIV affected special needs children and their families.

SCHEIS will continue to provide or subsidize direct specialty and subspecialty services to

CSHCN by funding Child and Adult Special Services which includes: eleven Child Evaluation Centers, five Cleft Palate Centers, three Tertiary Centers, six Genetic Centers, four Hemophilia Centers and five Sickle Cell Centers. The CEC Federation will continue to promote community based comprehensive services for CSHCN, as well as the availability of those services in New Jersey. Services will be provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			62	62	63
Annual Indicator			62.1	62.1	62.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63	64	64	65	65

Notes - 2004

The data reported in 2003 and 2004 are pre-populated with the 2002 data from the State estimates from SLAITS.

a. Last Year's Accomplishments

SCHEIS continues to ensure accessibility of Children with Special Health Care Needs (CSHCN) to primary and specialty care through the support of specialized pediatric services and County Case Management Units. However, challenges remain in access to care for uninsured CSHCN, with a slight increase in the reported number of uninsured served by CSHCN programs in 2004. Health insurance data extrapolated from the combined CSHCN programs estimate that nearly 4.5% of the 42,000 CSHCN served in 2004 self-identified as uninsured, as compared to 3.5% of the 42,080 CSHCN children served in 2003 and 6.0% in 1999. Although the advent of NJ FamilyCare expanded insurance coverage for those up to 350% FPL, changes in eligibility that prevent enrollment of parents/adults may have influenced the slight increase in those reported as uninsured. Improvements in the reporting of insurance type are expected to reduce the percentage of unknowns. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. County Case Management		X		
2. Subsidized Direct Specialty and Subspecialty Services	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Despite challenges created by a rapidly changing health care environment, SCHEIS has continued to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN). The CSHCN programs in New Jersey have traditionally provided and/or financed specialty and subspecialty care services through a network of specialty clinics. More emphasis continues to be placed on providing care coordination through the County Case Management Units. With many families transitioning to managed care, the care coordination services of County Case Management Units are now even more important to ensure comprehensive care due to potential restrictions created by utilization review, referral requirements, and closed panel networks. Anecdotal experience this past year has proven the benefits of the County Case Management Units who have assisted families in navigating the complicated managed care system to obtain necessary services.

c. Plan for the Coming Year

SCHEIS will continue to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN). With transition of children served by the Department of Human Services, Division of Youth and Family Services, into Medicaid Managed Care targeted for enrollment in 2004, SCHEIS will continue to collaborate with other Medicaid Managed Care Alliance members to enhance existing access to specialty and subspecialty services. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			75	76	77
Annual Indicator			75.9	75.9	75.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78	79	80	80	81

Notes - 2004

The data reported in 2003 and 2004 are pre-populated with the 2002 data from the State estimates from SLAITS.

a. Last Year's Accomplishments

In 2004, SCHEIS, and the Statewide Parent Advocacy Network (SPAN), continued collaborative efforts to ensure access to care for CSHCN. Family input is on services through participation at Family Centered Care Services provider meetings, both as attendees and presenters; including transition, advocacy and support.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Statewide Parents Advocacy Network		**X**		
2. Parent-to-Parent Network		**X**		
3. Family Voices parent group		**X**		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaboration between the Statewide Parent Advocacy Network (SPAN) and SCHEIS, which began eleven years ago, has enhanced the provision of accessible family-centered care. SPAN is the only federally funded parent training and information center for parents of children with disabilities and special health care needs in New Jersey. During 2004, eleven Case

Management Units housed 14 SPAN Resource Parents who provided technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. The Resource Parents documented nearly 6800 contacts with families and professionals during that time. In addition, SCHEIS provided funding in 2002 for a project enabling volunteer parents trained through SPAN to provide statewide coverage for the New Jersey Parent-to-Parent Program. As another statewide initiative, SCHEIS continues to collaborate and partially support a Family Voices chapter, whose mission is to provide parents with training in family leadership, policy making, and advocacy in health care.

In addition, the Case Management units have collaborated and developed a standardized Family Satisfaction Survey intended to assess the family's experience with case management services, responsiveness to needs and effectiveness of referrals. The Family Satisfactions Survey was piloted and will become standardized for use statewide in 2006.

c. Plan for the Coming Year

Collaboration between the SPAN and SCHEIS will continue to enhance the provision of accessible family-centered care. SPAN Resource Parents will provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. SCHEIS will continue to collaborate and partially support a Family Voices chapter.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			5	6	7
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	10	12	14	16

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The 2002 indicator has been entered as an estimate for 2003.

Notes - 2004

The data reported in 2003 and 2004 are pre-populated with the 2002 data from the State estimates from SLAITS.

a. Last Year's Accomplishments

In addition to ongoing transition to adulthood information, referral, counseling and support provided by Family Centered Care grantee's case managers, SPAN Resource Specialists, social work and medical staff, multiple transition trainings were conducted in 2004, through parent and provider organization collaborations. As members of the ARC of New Jersey's Mainstreaming Medical Care Executive Committee, Family Centered Care staff assisted in developing and conducting a training for parents of CSHCN at the ARC of New Jersey's 15thAnnual Mainstreaming Medical Care Conference. Presentation topics included accessing care for the developmentally disabled, dental care, and medications for dual eligibles. Likewise, parent and professional training was provided through collaboration with the NJ SSI Alliance, an association of SSI stakeholders including consumers, State agencies, and advocacy groups. Approximately 250 attendees participated in the 6th Annual NJ SSI Alliance Conference. Targeting SSI and SSDI enrollees, the 2004 conference included topics such as how to access SSI benefits, medical and school to work transition, Ticket to Work, PASS, NJ Workability and other benefits available to persons eligible for Medicaid and/or Medicare.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition for sickle cell youth		X		
2. Transition planning for youth with hemophilia		X		
3. Transition to adulthood needs assessment				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling transition to adulthood for CSHCN is approached through several ongoing collaborative efforts between Family Centered Care Services staff, intergovernmental agencies, and parent advocacy groups. Since 1993, Family Centered Care Services staff collaborated with staff from the Social Security Administration, New Jersey Epilepsy Foundation, Department of Labor Vocational Rehabilitation and Disability Determination units, Department of Human Services Medicaid and Mental Health units, advocacy groups such as SPAN, Community Health Law Project, Family Voices New Jersey, Legal Services of New Jersey and others, on the development of the New Jersey SSI Alliance. The SSI Alliance meets quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and supports, which are invaluable to youth transitioning to adulthood.

In addition, a draft transition to adulthood packet has been developed through a pilot project conducted in collaboration with SPAN and the Essex Healthcare Foundation, at the Essex

County SCHS case management unit. The packet targets families with CSHCN and includes information on Department of Education Section 504 basic rights, Individual Health Plan development, SPAN, SCHS, and a description of the New Jersey Catastrophic Illness in Children Relief Fund financial assistance program. Distribution of the packet to CSHCN age 13 and older served through the county case management units is underway. Likewise, during 2004, a statewide training about transition to adulthood was conducted by SPAN for parents of CSHCN, and staff of the SCHS Case Management Units, Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Centers, Family Centered HIV Centers, and HMO case managers.

c. Plan for the Coming Year

The SSI Alliance will continue to meet quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and support, which are invaluable to youth transitioning to adulthood. The sixth annual SSI Alliance Conference will again target SSI enrollees and professionals, and is scheduled for fall 2005.

As a result of collaborative between Title V, the Academy of Pediatrics, SPAN and the Epilepsy Foundation of New Jersey (EFNJ) a statewide needs assessment targeting transition to adulthood for children and youth with special health care needs is proposed for 2005. Rutgers University researchers will be contracted to analyze New Jersey specific SLAITS data, and collaborate SPAN and/or EFNJ's efforts to conduct focus groups, and survey health care providers to determine transition to adulthood needs for New Jersey youth.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	71	73	74	75	76
Annual Indicator	71.2	73.1	76.1	75	78.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79	79	80	80	81

Notes - 2004

Data is from the National Immunization Survey at the CDC
http://www.cdc.gov/nip/coverage/NIS/
No numerators or denominators are available.

Provisional data available as of 5/23/2005 for 2004 from the Q3/2003-Q2/2004 National Immunization Survey

a. Last Year's Accomplishments

New Jersey has achieved a 75% age appropriate immunization rate in 2003, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Immunization Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers (FQHCs), and other pediatric clinics. The State's Vaccines for Children Program became available to private practitioners for the first time in 1999. The Division of Family Health Services (FHS) continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Immunization Program in Communicable Disease				X
2. NJIIS web-based registry			X	
3. New Jersey Vaccines for Children Program			X	
4. Local health department child health conferences		X		
5. Universal Child Health Record for all children in child care			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The New Jersey Department of Health and Senior Services began the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry in April 2003, through a series of introductory efforts sponsored by the seven regional maternal child health consortia. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. Interfaces with private insurance carriers have been completed and they will be able to populate the registry as well via physicians accounting entries once the enabling legislation completes its way through the State Legislature. A new, nationally sponsored program, NICHQ, has been joined by DHSS and the New Jersey Chapter of the American Academy of Pediatrics to facilitate the introduction of the Immunization Registry into practice sites in targeted areas of particular need. Similar efforts are on going with the Academy of Family Practice of New Jersey as well. The Registry interfaces with the programmatic requirements of WIC and Medicaid.

Since the utilization of the Federally Qualified Health Centers (FQHCs) by the residents of New Jersey who lack health insurance is a priority in the State, the New Jersey Primary Care Association, in cooperation with the Reproductive and Perinatal Health Services, initiated an FQHC Project to utilize the Family Health Line 1-800 number to guide callers to the seventeen FQHC centers and their satellite stations throughout the State effective April 1, 2004 to December 31, 2004. The New Jersey Primary Care Association hired a marketing firm that conducted a major bus advertising campaign to encourage people to call the 1-800 number. The Family Health Line took charge of data collection that was monitored by the program. As a

result, a total of 1,916 FQHC calls were received and referred by the Family Health Line.

c. Plan for the Coming Year

FHS continues to work collaboratively with the Immunization Program to promote age appropriate immunizations. All newborn infants in New Jersey will be automatically entered into the system at birth via the Electronic Birth Certificate to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through record sharing. Interfaces with private insurance carriers and physician offices will also contribute to populating the registry.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	18	17.5	17	16.5	16
Annual Indicator	15.9	16.9	16.1	15.4	12.5
Numerator	2539	2557	2478	2424	2216
Denominator	159548	150917	154388	157765	176780
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12.5	12.4	12.3	12.2	12

Notes - 2004

Source of 2000 to 2003 data is the Electronic Birth Certificate (EBC) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Provisional 2004 data is from a provisional EBC file as of 6/18/2005. Census estimate for females 15-17 is from the Population Division, U.S. Census Bureau, March 10, 2005.

a. Last Year's Accomplishments

Seventeen family planning agencies with 60 clinical sites provided comprehensive reproductive health services to over 33,000 adolescents each year to assist the Title V program to meet National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. Clinical services are provided including physical assessment, laboratory testing and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities that deal with decision-making, value clarification and establishing linkages with youth-serving agencies were encouraged. Educational activities focused on primary pregnancy prevention activities that

encourage family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. All family planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle, injury prevention, drug, alcohol and tobacco prevention, as well as sexually transmitted disease (STD) and pregnancy prevention.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Agencies providing comprehensive reproductive services	X		X	
2. Collaborate with Dept. of Human Services Adolescent Pregnancy Prevention Program				X
3. Adolescent Pregnancy Prevention Advisory Council				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In addressing NPM # 8 Teen (15-17) Birth Rate, collaboration with the Department of Human Services, the Department of Education, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month (May).

Additionally, this interdepartmental workgroup continues to facilitate cohesive, integrated statewide systems that provide comprehensive pregnancy, prevention services for young people. Presently, the workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies. Also, intradepartmental planning is underway for the 8th Annual Day of Learning, which has recently broadened in scope to include peer leadership training on teen pregnancy and HIV/STD prevention. As a result, this program is now referred to as the Teen Prevention and Education Program (Teen PEP), and a "Day of Learning" has been held annually in May to highlight pregnancy prevention month.

Annually, the interdepartmental workgroup co-sponsors an Adolescent Health Institute in

November. This one-day program was established for the purpose of bringing together adolescent stakeholders from throughout the state who are given an opportunity to participate in a forum that will provide up-to-date information and resources as they pertain to the many issues and challenges facing New Jersey youth.

c. Plan for the Coming Year

Family planning agencies with 60 clinical sites will continue to provide comprehensive reproductive health services to over 33,000 adolescents each year to assist the Title V program to meet National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. MCH resources also continue to support a Young Fathers Program in Newark. Adolescent Health Institute was held on November 19, 2004. The subjects were chosen as a result of current trends, news, television, conversations with professionals who expressed concerns about specific adolescent issues. They were: "Gay Lesbian, Bisexual, Transgender and Questioning Youth (GLBTQ)." Participants in this workshop will begin to explore and define terminology relevant to working with lesbian, gay, bisexual, transgender, and questioning adolescents, including basic definitions and familiarity with "allies" and the "coming out" process. Participants will carefully examine the specific issues that are unique to working with a GLBTQ population including experiences of GLBTQ youth of color, school harassment and homophobia, and the responsibilities of youth-serving professionals. The workshop will close by discussing how these issues can affect health education and counseling interactions. "Integrating Skill-Based Abstinence Education into Faith-Based Settings." This workshop will look at some of the current curricula on developing skills to support abstinence in faith-based settings. Participants will have an opportunity to explore the ideology regarding abstinence and more importantly, to examine the skills young people need to support abstinence in their lives.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	42	42	42	43	43
Annual Indicator	42.0	NaN	NaN	42.6	42
Numerator	940	0	0	803	
Denominator	2237	0	0	1883	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	44	44	45	45	46

Notes - 2002

No data is available for 2002.

Notes - 2003

2003 data based on the NJ Dental Sealant Survey 2003. A random sample of 35 schools participated. All third graders in the schools took home the single question survey instrument worded "Does your child have a sealant on a back tooth?"

Notes - 2004

2004 data is based on the NJ Dental Sealant Survey conducted during the 2004-2005 school year which gave a statewide estimate of 42% of third grade students with sealants.

a. Last Year's Accomplishments

In the area of oral/dental health, support continues for three regional programs that employ dental hygienists who act as regional dental coordinators providing oral health education to preschool and elementary school students through the Cavity Free Kids program and Save Our Smiles, a school fluoride mouth rinse program, serving over 125,000 children. These programs were expanded in 2002 with state funds. . A survey of third grade children in a sample of 46 elementary schools conducted in January 2001, found that 42% of parents reported their child had protective sealants on at least one permanent molar. The sealant survey of third grade children was repeated in early 2003 and found the similar result that 42.6% of parents reported their child had protective sealants on at least one permanent molar. The dental sealant survey was also conducted in a random sample of 40 schools statewide during the 2004-2005 school year and found a statewide estimate of sealants present in 42% of third grade students. Results were almost identical to the surveys conducted in 2001 and 2003. DHSS and regional oral health staff participated in the statewide "Give Kids a Smile" day in January 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Federally Qualified Health Center (FQHC) Expansion	X			X
2. Physician/Dentist Loan Redemption Program				X
3. Regional Oral Health Promotion Programs			X	X
4. Give Kids a Smile Day			X	X
5. Cavity Free Kids Programs in Child Care			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Federally Qualified Health Centers (FQHC) Expansion program continues to provide financial support of dental health services. Additionally, the Physician/Dentist Loan Redemption Program has placed 11 more dentists in underserved areas of the State.

c. Plan for the Coming Year

To improve pediatric oral/dental health, the Cavity Free Kids program and the Save Our Smiles program will continue to provide oral health education to preschool and elementary school students. The FQHC Expansion program will continue to provide financial support of dental health services and the Physician/Dentist Loan Redemption Program will work to place more dentists in underserved areas of the State. Collaboration will continue with the New Jersey

Dental School and the New Jersey Dental Association to promote "Give Kids a Smile Day" in 2005. The state supported FQHC capacity building effort will work to increase access to dental services.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	2.2	2.1	2	1.9	1.7
Annual Indicator	1.4	2.0	1.6	2.0	
Numerator	25	34	28	34	
Denominator	1734603	1739257	1775525	1738140	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.6	1.6	1.5	1.5	1.4

Notes - 2003

Data source - CDC National Center for Injury Prevention and Control website www.cdc.gov/ncipc/wisqars/.
ICD-9 Codes: E810-E825, E958.5, E988.5
ICD-10 Codes: V30-V39 (.4-.9), V40-V49 (.4-.9), V50-V59 (.4-.9), V60-V69 (.4-.9), V70-V79 (.4-.9), V81.1 V82.1,V83-V86 (.0-.3), V20-V28 (.3-.9),V29 (.4-.9),V12-V14 (.3-.9),V19 (.4-.6), V02-V04 (.1,.9),V09.2,V80 (.3-.5),V87(.0-.8),V89.2

Notes - 2004

No provisional data is available to estimate mortality rates for 2004.
A provisional 2004 death certificate file should be available in Fall 2005.

a. Last Year's Accomplishments

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes has declined since 1997 both in New Jersey and in the United States.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. POrSCHe home visiting projects		X		

2. Healthy Child Care Initiative safety focus				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Although not specifically focused on deaths due to motor vehicle crashes, progress has been made on unintentional injury prevention activities. The Prevention Oriented System for Child Health (POrSCHe) projects instruct families in child safety including use of infant car seats and child restraint systems. Safety at home and in the child care center is one of the major focuses of the Healthy Child Care New Jersey Initiative.

c. Plan for the Coming Year

POrSCHe projects will continue in the coming year to instruct families in child safety including use of infant car seats and child restraint systems. The Healthy Child Care New Jersey Initiative will continue to emphasize safety at home and in the child care center.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	63	64	66	67	68
Annual Indicator	63.2	63.9	66.0	67.3	67.8
Numerator		69738	72240	73758	74463
Denominator		109166	109520	109596	109876
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	69	69	70	70	71

Notes - 2004

Source of data before 2001 is the Mothers Survey, Ross Products Division, Abbott

Laboratories. The numerator is breastfeed babies at hospital discharge, not the number of EXCLUSIVELY breastfeed babies at hospital dioscharge. Methodology of the survey is available in the publication, Breastfeeding Continues to Increase Into the New Millennium in Pediatrics 2002: 110: 1103-1109.

2001 to 2003 data is from Electronic Birth Certificate files which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. EBC rates are very close to Ross' Mothers Survey (for 2000, EBC 62.7 verse Ross 63.2). Numerator is newborns breastfed in 24 hours prior to hospital discharge. Denominator is newborns discharged home.

Provisional 2004 data is from the EBC.

a. Last Year's Accomplishments

In Healthy New Jersey 2010, there are two objectives for breastfeeding: 1) to increase the proportion of mothers who breastfeed their babies at hospital discharge to at least 75.0 percent and 2) to increase the proportion of breastfed infants who are breastfed exclusively at hospital discharge to 90.0 percent. The national breastfeeding objectives are for 75% of mothers to breastfeed in the early postpartum period, for 50% of new mothers to continue breastfeeding until their infants are six months old, and for 25% to breastfeed until one year.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in New Jersey continued to decline in 2004 (See Chart 9 attached to Table of Contents), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2004, exclusive breastfeeding at hospital discharge statewide was 37.4% while any breastfeeding (exclusive and combination feeding) was 67.8%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (84.0%) while Black non-Hispanic women were least likely to breastfeed (49.3%). White non-Hispanic and Hispanic women initiated breastfeeding at 68.8% and 70.2% respectively.

The exclusive rates were 48.6% for White non-Hispanic women, 39.2% for Asian non-Hispanic women, 22.7% for Hispanic women, and 21.3% for Black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services. Hospitals that follow the "Ten steps to successful breastfeeding" (WHO/UNICEF) have better breastfeeding on discharge rates.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Professional outreach and education through MCH Consortia			X	X
2. WIC funding of MCHC and local WIC agencies		X		X
3. Surveillance from EBC & applied research projects			X	
4. Integrating Breastfeeding Education to Eliminate Disparities Project (IBEED)				X
5. Supporting the development of breastfeeding friendly policies in child care settings				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Many hospitals employed International Board Certified Lactation Consultants who identify early signs of breastfeeding difficulties and suggest appropriate options to the patients and medical staff. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to five local WIC agencies and four MCH Consortia. WIC lactation consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC breastfeeding staff conducts professional outreach and education to healthcare providers who serve WIC participants.

In 2004, the Department of Health and Human Services Office on Women's Health launched the media portion of the national campaign to promote exclusive breastfeeding for six months. The campaign messages are the result of focus groups conducted around the country and target women, particularly African American women, who have no firm commitment to breastfeeding or formula feeding. The radio, TV, and print ads are expected to run through 2005.

The Southern New Jersey Perinatal Cooperative was the recipient of one of sixteen Community Demonstration Project (CDP) grants from the US Department of Health and Human Services Office on Women's Health and the Advertising Council. The grantees work to implement the National Breastfeeding Awareness Campaign on a local level. The CDPs aim to build self-efficacy by working to educate women about the benefits of breastfeeding, empower them to choose to breastfeed, and create awareness that breastfeeding is normal, desirable, and achievable.
The demonstration projects:
- Ensure that breastfeeding mothers have access to comprehensive, up-to-date, and culturally tailored lactation services provided by trained physicians, nurses, lactation consultants, and nutritionists/dietitians;
- Develop breastfeeding education for women, their partners, and other significant family members during the prenatal and postnatal periods;
- Establish family and community programs that enable breastfeeding continuation when women return to work in all possible settings;
- Develop social support and information resources for breastfeeding women such as hotlines, peer counseling, and mother-to-mother support groups;
- Encourage fathers and other family members to be actively involved throughout the breastfeeding experience.

The CDP grant to the Southern New Jersey Perinatal Cooperative continues with an emphasis on breastfeeding services for Spanish speaking breastfeeding women. Delivery hospitals and local WIC Programs coordinate so that WIC participants will be referred to WIC upon discharge for continued breastfeeding support services.

c. Plan for the Coming Year

The CDC Guide to Breastfeeding Interventions will be released. This Guide will provide evidence-based interventions for maternity care practices, that is, those that take place during the intrapartum hospital stay. The "Ten steps to successful breastfeeding" provides a framework for practices that support breastfeeding initiation and duration, and in fact, the

number of steps in place is predictive of breastfeeding duration. This Guide will be used to encourage New Jersey hospitals to determine if their policies and practices are evidence-based and to implement changes that are consistent with the Ten Steps.

The Health Resources Services Administration (HRSA) is planning to release "The Business Case for Breastfeeding," which will provide sample workplace policies and information on providing lactation rooms for breastfeeding mothers. After a review of the Business Case, ways to distribute and implement it will be explored.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	54	68	97	98	99
Annual Indicator	54.8	68.6	97.2	98.1	98.8
Numerator	57933	74869	105798	108690	108968
Denominator	105720	109166	108798	110843	110284
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

Notes - 2004

Data for 2000 to 2003 from Newborn Hearing Screening Program based on the Electronic Birth Certificate.

Provisional 2004 data from the Newborn Hearing Screening Program based on the EBC (as of 5/2005) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

a. Last Year's Accomplishments

The statewide implementation of an Electronic Birth Certificate (EBC) in 1997 now permits the Early Hearing Detection and Intervention (EHDI) Program to monitor the percent of newborns screened for hearing impairment before hospital discharge (National Performance Measure #12).
Current data indicates that for 2004, 99% of infants were screened prior to discharge.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Outreach to private practitioners				X
2. Amended regulation for universal screening				X
3. Hospital level surveillance reports			X	
4. Increase in follow up and diagnostic reporting for those who fail screening		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Using the EBC, the EHDI can also identify and track children at "high-risk" for hearing loss and those who failed initial electrophysiological screening tests. Newborn hearing screening rules with amendments were readopted effective May 15, 2000. The amended regulations include: 1) a requirement for all birthing facilities to provide electrophysiological hearing screening prior to discharge or before one month of age for all babies having indicators associated with hearing loss, and 2) a requirement for all birthing facilities to screen all newborns electrophysiologically, regardless of the presence or absence of risk factors, prior to discharge or before one month of age by the year 2002. All facilities must have a system of follow-up in place for infants who failed the screen. In January 2002, legislation was enacted mandating universal newborn electrophysiological hearing screening. The legislation reinforces the State's commitment to early identification of hearing loss and early entry into treatment/intervention.

In March 2002, SCHEIS received a 4-year grant from HRSA for Universal Newborn Hearing Screening. The focus of the grant is to strengthen the follow-up system for infants failing their hearing screens, and to provide findings to SPAN to increase the number of support parents for children with hearing loss from 10 to 75. From July 2001 to the present, the Newborn Screening and Genetic Services Program together with the Early Hearing and Detection and Intervention Program at the NJDHSS, have partnered with several agencies, including individual hospitals, physician groups, health care advocacy organizations and others to present information and education on the hearing screening requirements.

Site visits to all 64 active birthing facilities in the State we made during 2004 by the EHDI staff to observe screenings, review procedures, provide technical assistance and give suggestions for improvement in screening and follow-up. Quarterly reports were distributed to all hospitals comparing hospital performance to statewide averages and detailing children still needing follow-up. Educational programs were presented to physicians, nurses, early intervention staff, case managers, and hospital EBC staff. Worked through Statewide Parent Advocacy Network to increase trained parent-to-parent support providers for children with hearing impairment. Staff began drafting guidelines for early intervention providers for working with hearing impaired children.

c. Plan for the Coming Year

The EHDI program will increase efforts at improving follow-up rates, improve tracking through the system to Early Intervention services, conduct educational programs for professionals, and develop new and improved parent education materials.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	9	12	11	10.5	10
Annual Indicator	9.4	11.5	10.1	11.5	
Numerator	234728	226990	227609	264614	
Denominator	2505910	1974833	2253217	2291296	
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9.5	9	8.5	8	8

Notes - 2004

Source: the Annual Social and Economic Supplement (ASEC) of the Current population Survey (CPS), which is conducted by the Bureau of the Census for the Bureau of Labor Statistics. The age group is children 0-18 years old.
http://www.state.nj.us/health/chs/hic0003/hic0003.pdf#Tab2
No data is available for 2004.
2004 Data should become available Spring 2006

a. Last Year's Accomplishments

Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, New Jersey and the Federal government have joined as partners in NJ FamilyCare (formerly New Jersey KidCare). NJ FamilyCare, administered by the New Jersey Department of Human Services, started in 1998. As of March 2004 there were 98,850 children enrolled in the newly expanded NJ FamilyCare initiative and 68,795 adults enrolled in the NJ FamilyCare program. In the course of developing NJ FamilyCare, the State learned that many poor children who are eligible for free health insurance under the State's Medicaid program are not enrolled. The aggressive marketing and outreach programs designed to enroll children in NJ FamilyCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ FamilyCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. Of the approximately four percent of uninsured children who do not qualify for NJ FamilyCare or Medicaid, many experience temporary gaps in insurance coverage, usually as a result of changes in parental employment. If employer-sponsored health insurance continues to decline, NJ FamilyCare will not be able to reduce the overall number of uninsured children in the State. Unfortunately, the percentage of uninsured children in New Jersey has increased from 8.2% in 1999 to 11.5% in 2003.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach and Enrollment Plan				X
2. MOU with NJ FamilyCare				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To reduce the number of uninsured children in New Jersey (National Performance Measure #13), the Department of Health and Senior Services continues our collaborative relationship with the Department of Human Services, the lead agency for the NJ FamilyCare Initiative. Title V has included language within our specifications for health service grants to require agencies providing health enabling services to outreach and facilitate enrollment of potentially eligible children.

To address the limited enrollment of adolescents in New Jersey FamilyCare, NJDHSS is collaborating with the Department of Human Services and the Region II Field Office of the Health Resources and Services Administration (HRSA) in the NJ Family Care: Adolescent Enrollment and Utilization of Health Services project. While some outreach and enrollment activities have been targeted toward this population group through schools, these achieved limited success. Under the HRSA/Center for Medicare and Medicaid Services CompCare initiative, consultants from Health Systems Research, Inc. have interviewed State staff and key community informants, conducted focus groups with adolescents and parents, and are developing recommendations for addressing the barriers to adolescent enrollment in health insurance and utilization of appropriate health services. In 2003-04, this initiative has shifted focus to researching effective measures to outreach to New Jersey's large and diverse immigrant population.

c. Plan for the Coming Year

DHSS will continue to collaborate with the Department of Human Services, the lead agency for the NJ FamilyCare Initiative, to reduce the number of uninsured children. Under the HRSA/Center for Medicare and Medicaid Services CompCare initiative, consultants from Health Systems Research, Inc. have interviewed State staff and key community informants, conducted focus groups with adolescents and parents, and are developing recommendations for addressing the barriers to adolescent enrollment in health insurance and utilization of appropriate health services. Recommendations are also being developed for outreach to the diverse immigrant populations in New Jersey.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	96	96	97	97	97.5
Annual Indicator	NaN	96.3	97.4	96.8	97.5
Numerator	0	164016	184830	182592	181724
Denominator	0	170257	189740	188557	186477
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	97.5	98	98	98	98.5

Notes - 2004

Source of PM #14 - a report titled, New Jersey DMAHS Managed Care Enrollment, by HMO from the Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services. The report used for 2004 data is for the month of December 2004. Cummulative annual reports are not available. The data reported is from the NJ KidCare A-JC programs which should not include new SCHIP initiatives.

Data prior to 2001 is not available in the same format.

a. Last Year's Accomplishments

The Medicaid program in New Jersey is administered by the Division of Medical Assistance and Health Services in the Department of Human Services. The percentage of potentially-eligible children who have received a service paid by the Medicaid Program (97.5% in 2004) is reported monthly by the Office of Statistical Analysis and Managed Care Reimbursement.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Collaborate with Department of Human Services on EPSDT promotion activities				**X**
2. NJ CompCare project				**X**
3. POrSCHe case management projects		**X**		
4. Collaborate with DHS regarding lead poisoning prevention and screening projects			**X**	
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The Prevention Oriented System for Child Health projects (POrSCHe) continue in 11 of New Jersey's 21 counties. Six of the target areas are cities and five of the projects are county-based. The initiative began in January 1997. Approximately 1,100 families are being served annually by POrSCHe projects. The POrSCHe projects were designed as outreach case management models to assist primary health care providers. Through POrSCHe, families are provided services that include: identification of health, nutritional, or developmental problems; supportive anticipatory guidance in child growth and development and parenting skills training and counseling; specialized health education to promote age appropriate immunizations, healthy eating and safety habits including, but not limited, to car seat restraints; and regular health supervision visits to a primary care provider. Additionally, the home visitor provides assistance to parents in accessing community resources (WIC, Family Planning, housing, education, job training and other social services). Evaluation of the projects is based on performance and outcome measures including: linkage with a primary care provider; enrollment in WIC, Medicaid (NPM #14), age appropriate immunizations (NPM #7) and lead screening (SPM #3); follow-up to ensure decreasing blood lead levels for affected children; referral for all appropriate services; and increase in parenting skills as measured by Nursing Child Assessment Satellite Training (NCAST) instruments.

DHSS collaborated with the NJ Department of Human Services (DHS), Division of Medical Assistance and Health Services, in the development of materials promoting the use of preventive health services for children, particularly those covered under the Early and Periodic Screening, Diagnosis and Treatment program (EPSDT). These materials are distributed through DHSS-funded child health projects and through the HMOs that have DHS contracts to provide primary care to children enrolled in Medicaid.

c. Plan for the Coming Year

The Prevention Oriented System for Child Health projects (POrSCHe) will continue in target areas.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.6	1.5	1.5	1.5	1.6
Annual Indicator	1.6	1.6	1.5	1.6	1.5
Numerator	1769	1787	1735	1776	1713
Denominator	112588	111772	114559	112350	112051
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.5	1.4	1.4	1.4	1.3

Notes - 2004

Source of provisional 2003 data is the Electronic Birth Certificate file which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.
Source of provisional 2004 data is the EBC file as of 4/15/2004.

a. Last Year's Accomplishments

HealthStart prenatal providers have continued to provide comprehensive health services and maternity and newborn services in order to address very low birth weight live births (Performance Measures #15), very low birth weight infants delivered at facilities for high-risk deliveries (Performance Measures #17), and first trimester prenatal care (Performance Measures #18). The HealthStart prenatal care providers include 70 hospitals that provide maternity services; four HMOs contracted through the Department of Human Services, eight private physician practices, 11 FQHCs, four Planned Parenthood agencies, and three licensed ambulatory care agencies. All of the facilities are certified by Medicaid to provide HealthStart maternity services, and 90 are certified to provide presumptive eligibility screening.

Reproductive and Reproductive and Perinatal Health Services coordinated the Folic Acid Coalition of New Jersey Annual Meeting that was held on May 11, 2004 in Trenton. During the meeting, the Preconceptional Health Promotion/Folic Acid Initiatives and the March of Dimes Prematurity Initiative, as well as other activities, were reviewed and discussed. During Year 2004, Reproductive and Perinatal Health Services mailed 4,940 folic acid brochures in English and Spanish to target group populations through the eight Healthy Mothers/Healthy Babies (HM/HB) Coalitions, the Family Health Line and other community events.

During the grant Year 2003-04, the Family Health Line received and assisted 12,020 calls and made 13,763 referrals. Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The program coordinates quarterly staff trainings for the agency with an emphasis on current family health initiatives. In Year 2004, the trainings covered the Federally Qualified Health Center (FQHC) Project, the Governor's Mammography Campaign, the Lead Initiative, Diabetes Prevention and Prematurity/Folic Acid topics. Reproductive and Perinatal Health Services provides Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking.

The HM/HB Coalitions continued to play a key and significant role in integrating preconceptional health with their on-going MCH Programs, applying mass media, community event, health fair and group activity methods to reach the target group populations. Reproductive and Reproductive and Perinatal Health Services provided 12,725 brochures, i.e., 7,785 related to preconceptional health and 4,940 related to folic acid to the above mentioned agencies for statewide dissemination. In addition, 385 Family Health Line brochures, 1,000 immunization brochures and 415 Postpartum Depression (PPD) brochures were also disseminated making a grand total of 14,525 for Year 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			

	DHC	ES	PBS	IB
1. HealthStart				X
2. Preconceptual health counseling/training				X
3. Healthy Mothers / Healthy Babies coalition activities		X	X	X
4. Healthy Start		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Year 2004 Action Plan for the Preconceptional Health Promotion Initiative includes emphasis on newly selected preconceptional health risk factors, i.e., prematurity and lack of folic acid intake by prospective pregnant women and adults of childbearing age.

The Year 2005 Action Plan for the Preconceptional Health Promotion Initiative includes emphasis on newly selected preconceptional health risk factors, i.e., weight and pregnancy, smoking and pregnancy and lack of folic acid intake by prospective pregnant women and adults of childbearing age. Based on the above Action Plan, 5,000-10,000 pertinent brochures are planned for dissemination during Year 2005.

c. Plan for the Coming Year

The MCH Consortia, Healthy Mothers/Healthy Babies (HM/HB) Coalitions and the Family Health Line will continue to reach prospective pregnant women and to address issues related to LBW. Additional preconceptional health risk factors will be selected for emphasis in the Year 2005 Action Plan for the Preconceptional Health Promotion Initiative.

The MCH Consortia, Healthy Mothers/Healthy Babies (HM/HB) Coalitions and the Family Health Line will continue to reach prospective pregnant women and to address issues related to LBW. Additional preconceptional health risk factors will be selected for emphasis in the Year 2006 Action Plan for the Preconceptional Health Promotion Initiative.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4	3.7	3.6	3.5	3.5
Annual Indicator	5.5	3.5	2.8	3.1	3.1

Numerator	28	18	16	17	17
Denominator	510821	519337	562263	542420	542420
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	2.9	2.8	2.7	2.6

Notes - 2002

Data source - CDC National Center for Injury Prevention and Control website www.cdc.gov/ncipc/wisqars/.
ICD-9 Codes: E950-E959
ICD-10 Codes: X60-X84, Y87.0

Notes - 2003

Data source - Provisional single casue of death file for 2003 as of 6/2005.
ICD-9 Codes: E950-E959
ICD-10 Codes: X60-X84, Y87.0

Notes - 2004

No provisional data is available to estimate mortality rates for 2004.
A provisional death certificate file for 2004 should be available in Spring 2006.
Provisional single cause of death file for 2003 entered as estimate for 2004.

a. Last Year's Accomplishments

DHSS supports the Mercer County Traumatic Loss Coalition, which brings together a wide variety of community partners (including schools, local government, police, fire and EMS, and health care providers) to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents. Since FY 2001 state funds have been budgeted to replicate this coalition in the other 20 counties in New Jersey.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. NJ Suicide Planning Team				**X**
2. Traumatic Loss Coalitions in 21 counties		**X**		**X**
3. 'Managing Sudden Traumatic Loss in the Schools' - Manual				**X**
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

"Managing Sudden Traumatic Loss in the Schools" (revised edition) is made available to

schools and other youth serving organizations upon request. The document outlines a model for responding to the needs of the general school population after a suicide, homicide or sudden accidental death.

c. Plan for the Coming Year

DHSS continues to work with a wide variety of community partners, such as the Mercer County Traumatic Loss Coalition, to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	87	87	87	88	88
Annual Indicator	87.2	87.1	87.9	84.5	83.8
Numerator	1507	1556	1498	1501	1435
Denominator	1729	1786	1704	1776	1713
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	86	87	87

Notes - 2004

Facilities for high risk deliveries defined as Intermediate, Intensive and Regional Perinatal Centers.
Data for 2000 to 2003 data from Electronic Birth Certificates which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.
Provisional 2004 data from EBC as of 4/15/2005.

a. Last Year's Accomplishments

The state has made consistent progress on NPM #17. However, despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early admissions to prenatal care and comprehensive services, we have not observed improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status Indicators. The rapid increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Consortia TQI Activities				X
2. Perinatal Designation Level regulations				X
3. MCH Task Force on Hospital-based perinatal and pediatric services				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates has increased through continuous quality improvement (CQI) activities, which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC). The FHS/Perinatal Services coordinates regional continuous quality improvement activities within each of the six regional maternal and child health consortia. Regional quality improvement includes the regular collection and analysis of data, designed to identify the nature and severity of health-service problems. Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children two years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through fetal-infant mortality review and maternal mortality review systems, as well as analyzing data collected through the electronic birth certificate. The electronic birth certificate (EBC) is the primary data source used by the Consortia. Currently, all hospitals providing maternity services report births through the EBC. The Consortia monitor the accuracy of data entered into the EBC and provide training and technical assistance as needed. Data collected by each Consortium through the EBC reflects births that occur in each Consortium's member hospitals only. The MCH Consortia recommend, implement, and monitor corrective action, based upon the data collected. A multidisciplinary committee that includes representation from member hospitals and the community oversees the total quality improvement process within the Consortium. Data collected through the EBC and the New Jersey Maternal Mortality Review and New Jersey Fetal-Infant Mortality Review are presented to the Consortium TQI Committee. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region. Data and information gleaned from regional TQI activities is forwarded to the Department of Health and Senior Services, Maternal, Child and Community Health/Reproductive and Perinatal Health Services, which will be included in a combined database used for planning on a statewide level.

The New Jersey March of Dimes Prematurity Campaign is a partnership between Johnson and Johnson Pediatric Institute, American College of Obstetricians and Gynecologists, Association of Women's Health, Obstetric and Neonatal Nurses, American Academy of Pediatrics, Matria

and the Departmen

c. Plan for the Coming Year

The Department convened a Maternal and Child Task Force on Hospital-based Perinatal and Pediatric Services. The Task Force is being convened by the Department to examine whether the current regulatory system, including certificate of need and licensure rules, governing hospital-based perinatal, neonatal and pediatric services, is consistent with changes in medical practice. Nominations for membership on the Task Force were solicited from various constituencies involved with maternal, child and family health. Nominees have a wide range of expertise including physicians, nurses, administrators and other disciplines. The Division will continue to participate on the March of Dimes Prematurity Campaign statewide planning committee. The Reproductive and Perinatal Health Services Program Manager participated on the planning committee for the November 2004 Prematurity Summit with over 150 participants attending. The conference planning committee for the Fall 2005 conference is in process.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	78	78.5	78.5	79	79
Annual Indicator	80.4	75.8	78.9	79.2	78.6
Numerator	85824	84726	87874	89022	88086
Denominator	106787	111772	111338	112350	112051
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79	79	79.2	79.2	79.4

Notes - 2004

Data for 2000 to 2003 data from Electronic Birth Certificates which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.
Provisional 2004 data from EBC as of 4/15/2005.

a. Last Year's Accomplishments

Through the Healthy Mothers/Healthy Babies (HM/HB) Coalition program, the enabling services of outreach, supportive services, and education are provided to improve maternal and infant care (National Performance Measures #18, #5, #17, and Health Status Indicators #2, #3, #4, #5). The percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester and the percentage of infants born to pregnant women receiving adequate prenatal care (Kotelchuck Index) have increased from 2000 to 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers / Healthy Babies coalition activities				X
2. MCH Consortia outreach and education activities				X
3. HealthyStart				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Southern New Jersey Perinatal Cooperative in conjunction with the Atlantic City HM/HB Coalition is providing bilingual outreach workers accompanied by bilingual interpreters to perform door-to-door canvassing and educational activities. This program locates women who have missed prenatal appointments and assists new mothers in obtaining pediatric care for their children. Age appropriate immunizations and comprehensive pediatric and prenatal care are the focus of the outreach activities. The target is approximately 200 referrals to services annually. The Camden HM/HB Coalition uses the canvassing and referrals to identify women between the ages of 20 and 35 who are in need of more intensive contact based on initial evaluation and to subsequently enroll them in case management. Pregnant women not in care are identified. Health Advocates will assist in making appointments and appropriate referrals for these women and will provide follow-up care. Barriers to care are identified and reported to their Community Network Committee.

In the Northern New Jersey Maternal and Child Health Consortium, the Paterson HM/HB Coalition operates a Safety Net Program. This Program is designed to reduce infant morbidity and mortality through a collaborative patient retrieval effort. An Outreach Worker assists local providers in locating women and children delinquent in obtaining scheduled health care. The Outreach Worker attempts to locate the client, advise them of the benefits of returning to care and assists the client in complying with the scheduled plan of care. Women are also identified through door-to-door canvassing and receive prenatal or preconceptional education and referrals. The goal is to identify and educate 500 women on the benefits and availability of care.

c. Plan for the Coming Year

The enabling services of outreach, supportive services, and education will continue to be provided to improve prenatal care through the Healthy Mothers/Healthy Babies (HM/HB) Coalition program.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percentage of Black non-Hispanic preterm infants in*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13.7	135	13.4	13.3	13.2
Annual Indicator	13.3	13.3	13.5	13.4	11.6
Numerator	2420	2356	2339	2256	1912
Denominator	18183	17737	17310	16872	16447
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13.2	13.1	13	13	

Notes - 2004

Source: Final Birth Certificate files from the Center for Health Statistics. Preterm defined as less than 37 weeks gestation by exam from the birth certificate.

Source of provisional 2004 data is the Electronic Birth Certificate file as of 6/18/2005 which include births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

a. Last Year's Accomplishments

Maternal, Child and Community Health chose the percent of black preterm births in New Jersey as State Performance Measure #1. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Mothers /Healthy Babies Coalitions			**X**	**X**
2. Healthy Start		**X**		**X**
3. Preconceptual health counseling/training				**X**
4. HealthStart				**X**
5. MCH Consortia outreach and education activities			**X**	**X**
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Reproductive and Perinatal Services has implemented program evaluation of all funded BIMR activities statewide.

c. Plan for the Coming Year

Two meeting will be convened by the Black Infant Mortality Resource Center for participation by all funded projects. This will provide an opportunity for the projects to network and share "lessons learned". In addition, funded projects will review the data from the projects to determine the most effective means of client recruitment and retention.

State Performance Measure 3: *The percentage of Regional MCH Consortia implementing community-based Fetal and Infant Mortality Review (FIMR)Teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	7	7	7	7	6
Denominator	7	7	7	7	6
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2004

As of January 1, 2004 there are 6 MCH Consortia (denominator).

a. Last Year's Accomplishments

State Performance Measure #3 was selected to monitor progress toward the implementation of community-based Fetal and Infant Mortality Review Teams (FIMR). This infrastructure building service will impact on National Performance Measures #15, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

Related to FIMR is New Jersey's system of Maternal Mortality Review (MMR), which was established, in the late 1970s. In collaboration with a subcommittee of the Medical Society, the MMR was completed annually. However, the need to expand the MMR review team from the

traditional physician-based model to a multidisciplinary model, utilize consistent case abstractions and improve case identification as a need by the Division. Using Florida's PAMR system as a model, New Jersey began the task of revising our system. In collaboration with the Chair of the MMR subcommittee of the Medical Society, staff drafted a revised MMR protocol and presented the protocol to the full committee in May 1999. Representatives from MCCH, the six MCHC, and the Medical Society of New Jersey comprise the steering committee. The case review team membership was solicited from the six MCHC and a variety of professional organizations throughout the State.

The FHS/Perinatal Services coordinates the New Jersey MMR process. The New Jersey MMR Program is a statewide initiative modeled after the National FIMR process. This process uses standardized data collection and a multidisciplinary team for case review. In addition, a birth certificate, death certificate and hospital discharge data matching strategy is used to improve identification of maternal deaths using the CDC expanded definition of pregnancy-associated death.

Once cases are identified, Perinatal Services obtains copies of death certificates, which are forwarded to the Central NJ Maternal and Child Health Consortia (CNJMCHC). The CNJMCHC coordinates data abstraction through a grant from DHSS. Data abstractors are nurses with extensive maternal and child health backgrounds, trained in medical data abstraction, and case summary development.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing NFIMR in six MCHC Regions				X
2. Implementation of FIMR process uniformly across all projects				X
3. Reporting of data and local findings to NJDHSS for inclusion in statewide database				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The number of FIMR projects statewide continues to be nine, of which seven are funded with MCH block grant monies through the six regional maternal and child health consortia. In order to assure a process that will allow for coordination of New Jersey FIMR findings from a statewide perspective, the process is implemented uniformly across all projects. All local projects of New Jersey FIMR follow the National FIMR guidelines for community FIMR with modifications as needed for New Jersey. The data collection process includes both chart abstraction and a maternal interview. A multidisciplinary case review team reviews the information and based on findings, makes recommendations to a Community Action Team. Data and findings from FIMR projects are submitted to the NJDHSS for inclusion in a statewide database.

Obtaining the maternal interview continues to be an impediment to the process. The success in obtaining maternal interviews has improved through the use of nurses through contracting with a local health department or VNA. However, obtaining a maternal interview continues to be a challenge.

On a local level, the MCH Consortia have used FIMR as a component of their quality improvement program both for need assessment and program development. Findings are shared with member hospitals for use in quality assurance activities. Policy has been implemented, such as the promulgation of fetal autopsy guidelines and consumer and professional education initiatives have addressed findings such as inadequate knowledge of fetal kick count and premature labor, and bereavement support issues.

Until the implementation of the New Jersey FIMR, there has not been a statewide approach to FIMR. Therefore, FIMR findings have not played a major role in need assessment and quality improvement at the state level. NJDHSS and the MCH Consortia are now working collaboratively to use the information obtained from New Jersey FIMR for policy development and continuous quality improvement activities on the state and local level. In addition to issuing a Statewide Annual New Jersey FIMR report, common areas of concern identified from the local reviews will be addressed as a collaborative effort by all local projects through statewide initiatives.

Concerning MMR, all pregnancy-associated deaths occurring in 1999, 2000 and 2001 have been reviewed, for a total of 152 pregnancy-associated deaths. The Case Review Team, which also serves as the Community Action Team, has reviewed the findings and made recommendations. A report of the findings and recommendations will be released shortly.

c. Plan for the Coming Year

All local projects of New Jersey FIMR will follow the National FIMR guidelines for community FIMR in order to assure a process that will allow for coordination of New Jersey FIMR findings from a statewide perspective. Data and findings from local FIMR projects will continue to be submitted to the NJDHSS for inclusion in the statewide database. To improve the completion of maternal interviews in the coming year all projects will use public health nurses to obtain the maternal interview.

The Reproductive and Perinatal Health Services will continue to coordinate the New Jersey Maternal Mortality Review process modeled after the National FIMR process.

State Performance Measure 4: *The percentage of children with elevated blood lead levels (>=20 ug/dL).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	0.6	0.5	0.4	0.4
Annual Indicator	1.0	0.6	0.5	0.5	0.3
Numerator					

	1309	947	934	832	543
Denominator	137536	149233	171712	172932	167018
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0.3	0.3	0.2	0.2	0.2

Notes - 2004

Children (0-6) with elevated blood lead levels (>=20 ug/dL) reported to the New Jersey Childhood Lead Poisoning Prevention Surveillance System (CLPPSS) for calendar year 2004.

a. Last Year's Accomplishments

The percent of children with elevated blood lead levels (State Performance Measure # 3) was chosen because children in New Jersey have a higher than average exposure to lead in their environment and a higher percentage of elevated blood lead than the national average. In State FY 2004, 2.7% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels. Children with elevated blood lead levels are at increased risk for behavioral, physiological and learning problems. Increased childhood morbidity will result from undetected and untreated lead poisoning.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During State FY 2004, more than 190,000, blood lead tests were reported on 181,265 children. Of these, 92,645 were between six months and 29 months of age, the ages at which state rules require all children to be screened for lead poisoning. This is 41.6% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that for FY 2004 75.0% of children who were two-years old during SFY 2004, and 35.5% of one-year-olds, have had a least one blood lead test during their lifetime. Of the children tested, for FY 2004 2.7% had results > 10 ug/dl and < 0.5% had results > 20 ug/dl.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Registry and universal reporting			**X**	
2. Newark Partnership for Lead Safe Children				**X**
3. Medicaid collaboration on pilot screening projects				**X**
4. Regional Childhood Lead Poisoning Prevention Coalitions			**X**	**X**
5. Plan for Elimination of Childhood Lead Poisoning in New Jersey				**X**
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In May 2004, the DHSS published the FY 2002 Annual Report on Childhood Lead Poisoning in

New Jersey for dissemination of this data to local health departments and the public.

Working with the State's Immunization Program, the childhood lead poisoning prevention section of Child Health has developed a lead screening module for the Immunization Registry. Information from the lead data system will be downloaded into the Immunization Registry for easy retrieval by practitioners and the data from the Immunization Registry will be used to update the lead database as appropriate. The WIC Program has included within its database a module on immunizations, which also interfaces with the Immunization Registry. Additionally, Child Health staff have participated in a collaborative effort with Medicaid and its contracted managed care providers to increase the number of Medicaid-enrolled children screened for lead poisoning. These efforts have involved child care as access points for lead poisoning prevention education and screening in collaboration with local health departments and other community agencies.

All children with elevated blood lead levels that require public health intervention are eligible for POrSCHe services (described earlier in this section) in target areas. Children in other areas of the State with elevated blood lead levels are served by their local health department as required by the State Sanitary Code (Chapter XIII).

DHSS is working in collaboration with the Department of Human Services, which is responsible for Medicaid and SCHIP in New Jersey, on sponsoring pilot projects to test the effectiveness of innovative methods to promote lead screening. These projects are in the cities of Camden and Irvington. The projects started in August 2002, and will be evaluated through December 2003. The projects were expanded to include Paterson, Jersey City, and Bridgeton/Millville in 2004.

In the highest risk city, Newark, the Child and Adolescent Health Program has partnered with the Newark City Department of Health and Human Services (DHHS) to establish the Newark Partnership for Lead Safe Children. The partnership has enlisted the support and participation of over 50 agencies/organizations in Newark. The partnership has been designed to empower the city and participating organizations to "take charge" of the lead problem in Newark. Newark DHHS has implemented a citywide lead poisoning prevention education initiative: "Lead Free is Best for Me". A small passenger van donated to the partnership by one of its members has been converted into "Leadie Eddie" - a mobile lead poisoning prevention exhibit that travels to childcare centers and community sites to do education programs and lead screening.

c. Plan for the Coming Year

In January 2003, the DHSS provided new funds to establish regional childhood lead poisoning coalitions. Coalitions were formed in four regions, covering the whole state. The coalitions are comprised of the regional Maternal and Child Health consortia and local health departments, with community partners.

Collaboration with the State's Immunization Program will continue to complete the lead screening module for the Immunization Registry. Collaborative efforts with Medicaid and its contracted managed care providers will continue in order to increase the number of Medicaid-enrolled children screened for lead poisoning.

New Jersey Department of Health and Senior Services introduced a new initiative, Wipe Out Lead New Jersey (WOLNJ), to assist expectant families in identifying harmful lead dust hazards in the home. A free lead dust test kit will be distributed to pregnant women living in cities most a risk for lead poisoning, through prenatal providers and FQHCs. This program will be implemented through the collaborative efforts of regional Maternal and Child Health Consortia (MCHC) and the statewide subsidiary of Southern New Jersey Perinatal Cooperative, Family Health Initiative (FHI).

WOLNJ staff will collaborate with the MCHC perinatal outreach staff to assist clients in performing the test and returning the sample to the lab. They will also provide on site lead poisoning prevention education to immediately minimize risk of exposure for the pregnant women and fetus. Once the test is mailed to the lab and analyzed, the results will be sent to FHI, who will work with the MCHC to activate needed follow-up procedures. Immediate follow-up will include referral to local health departments and recommendations to test other children living or visiting the home under age six. Additional services include ongoing training for consortia outreach staff and prenatal providers, and a toll free telephone helpline to assist clients with the lead dust test.

State Performance Measure 5: *The percentage of repeat pregnancies among adolescents 15 - 19 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7	6.6	6.4	6.3	6
Annual Indicator	7.0	6.3	6.5	5.8	5.8
Numerator	559	484	477	406	404
Denominator	8012	7724	7334	7032	6917
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.7	5.6	5.5	5.5

Notes - 2004

Data from 2000 to 2003 from Electronic Birth Certificates which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.
Provisional 2004 data from the EBC as of 6/18/2005.

a. Last Year's Accomplishments

The percentage of repeat pregnancies among adolescent mothers 15-19 years of age (State Performance Measure # 4) was chosen because teen parents are more likely to have another child within two years, often leading to increased hardship and economic dependency. This state performance measure will also impact on National Performance Measure # 8. The percentage of repeat pregnancies among adolescent mothers 15-19 has decreased from 8.2% in 1998 to 5.8% in 2004.

The Adolescent Parenting Project (APP) serving Cumberland County continues to use a case management/home visiting model in order to reduce the rate of repeat pregnancy within 24 months of a first birth. It also promotes the physical and psychosocial health of low-income pregnant or parenting adolescents and their infants. Cumberland County is a rural area in the state and has the highest rate (14.7%) of teen (ages 10-19) births per County population in

New Jersey (Kids Count, 2002). Of the 88 adolescents served in the APP, the percent of parenting moms having a repeat pregnancy decreased from 3% to 1% from 2003 to 2004.

While the APP appears to have demonstrated success in reducing a repeat pregnancy, several caveats need to be acknowledged. First, the APP consisted of a self-selected group of teens who opted to participate in the APP. Second, insufficient data (two years) were collected in order to be able to determine whether or not there was a repeat birth. Finally, teens who did not participate in the APP were not followed up to determine whether they had a second repeat birth. This control group data is critical to establishing a true repeat pregnancy/birth rate among APP participants. Therefore, the APP repeat pregnancy/birth rate should not be used as a valid or comparable statistic-.

From 2003-2004, the percent of infants that had a regular pediatrician increased from 91% to 100%; the percent of pregnant/parenting teens enrolled with a primary provider increased from 94% to 100%; and, the percent that had a provider one year later increased from 64% to 68%. There have not been any substantiated cases of child abuse since the inception of the program.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Comprehensive services for teens through Family Planning sites	X			X
2. Demonstration parenting project		X		X
3. Advisory Council on Adolescent Pregnancy Prevention completion of 3 year strategic plan				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The APP currently case manages 88 pregnant/parenting adolescents up to age 18 years of age: 47% are Hispanic and 53% are non-Hispanic. To meet SPM #4, the program works with the teen moms to complete their high school or GED requirements, and monitors that both the mom and baby are linked with a primary care provider. The APP employs three full-time, licensed social workers (one is bilingual) who function as case managers. The case managers monitor the teen moms for their parenting skills and the home environment for safety and injury prevention measures. They also make referrals to needed community services. A part-time registered nurse conducts home visits as medically indicated, makes necessary referrals, counsels on family planning including education on sexually transmitted infections, HIV and AIDS, provides educational/vocational career goal planning, and teaches parenting skills. A new program activity was implemented in 2004 in partnership with School Based Youth Services Programs in two local high schools in which the nurse conducts group parenting classes that focus on building healthy parent-child and peer relationships.

c. Plan for the Coming Year

The Advisory Council on Adolescent Pregnancy Prevention continues to hold bi-monthly meetings that focus on the implementation of teen pregnancy strategies. They are planning a Children of Children's Exhibit in Central New Jersey in May of 2006. The statewide County Collaborative Coalitions and the regional forums continue to bring together stakeholders and to implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month.

In 2006, the APP will continue offering group parenting classes at the two local high schools. The staff is planning strategies on how to build community partnerships that will engage the community Federally Qualified Health Center (FQHC) and the local medical center in meeting prenatal educational needs of the pregnant teens through birthing classes, exercise and nutritional classes. There will be a continuing emphasis on the incorporating and using research-based "best practices".

State Performance Measure 6: *The percentage implementation of activities from the state plan to improve the nutritional and physical fitness of children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	50	75	90	95	100
Annual Indicator			90.0	90.0	100.0
Numerator		75	90	90	100
Denominator			100	100	100
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2004

The Child and Adolescent Health Program in the Division of Family Health Services is the source of SPM #6. SPM #6 will be modified in the future.

a. Last Year's Accomplishments

The New Jersey Council on Physical Fitness and Sports (NJCPFS) was established under Public Law 1999, Chapter 265 to promote the health of the citizens of New Jersey by developing safe, healthful and enjoyable physical activity and sports programs. The Council consists of the Commissioner of Health and Senior Services or their designee and 15 Governor-appointed public members appointed by the Governor, including one member each from the New Jersey Parks and Recreation Association, the Medical Society of New Jersey, the New Jersey State Interscholastic Athletics Association and the New Jersey Association of Health, Physical Education, Recreation and Dance. The Council held its first meeting in February 2001 and has scheduled monthly meeting s in lieu of the required quarterly schedule.

Accomplishments included:
- An updated Council brochure and letterhead, and an exhibit and banner to showcase Council activities,
- Co-sponsoring the annual sports medicine conference with the Sports Medicine Committee of the Medical Society of New Jersey,
- Updating Council By-Laws,
- Finalizing a 10-year strategic planning document,
- Sending a representative to the annual meeting of the National Association of State and Governors Councils,
- The addition of new resource members to the Council (older adults, diabetes, 5-a-Day), and
- Identifying organizations and other entities for future collaboration.

The Pedestrian and Bicycle Task Force is an advisory body to State, County and civic organizations, funded by the Department of Transportation through a grant to the Transportation Policy Institute, Voorhees Transportation Center, Edward J. Blaustein School of Planning and Public Policy. Membership is drawn from public, private and advocacy organizations that are concerned about the safety of the walking and biking public in New Jersey. The group meets on a bi-monthly basis to discuss topics related to pedestrian and bike safety, state obesity trends and feasible interventions related to the built environment, mobility and access and aims to improve pedestrian and bike facilities.

There are three Community Partnership for Healthy Adolescents (CPHA) grantees that are addressing the issue of nutrition and physical activity with adolescents in their community. These grantees implemented pedometer projects, with approximately 300 youth in the spring of 2004, to increase their level of physical activity.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Grant-funded projects:Community Partnerships for Healthy Adolescents & Isles, Inc.		X		X
2. KidStrong				X
3. NJ Council on Fitness and Sports & NJ Childhood Obesity Roundtable				X
4. NJ Obesity Prevention Task Force (PL 1999, Chapter 265) (A3534, PL 2003, Chapter 303)				X
5. Community or school-based pedometer programs and Bicycle safety programs		X		X
6. BMI school data survey and results				X
7. NJ Action for Healthy Kids and New Jersey PCORE (Pediatric Council on Research and Education) Obesity Prevention Project				X
8. NJ Pedestrian and Bicycle Task Force & PLAY Task Force				X
9. Safe routes to school State collaboration				X
10. Intergenerational School Breakfast Program and New Jersey 5 A Day Coalition				X

b. Current Activities

The NJCPFS met with the Governor to discuss opportunities for increasing the visibility of the Governor's Office in promoting physical activity to New Jersey citizens. These included: updating and moving NJCPFS web page from NJ Public Television's web page to the DHSS

web site; launching the Get Fit New Jersey web page which includes an interactive page with seasonal exercise opportunities, highlighted historic locations and a challenge with an incentive for New Jersey citizens to accomplish their fitness goals; participating in a press conference regarding the state efforts to impact obesity trends in New Jersey youth.

DHSS collaborated on the "Common Ground" conference that addressed the impact of the built environment on obesity. The DHSS Deputy Commissioner signed a commitment on behalf of the Department to collaborate on overlapping projects. Four hundred (400) pedometers and walking logs were distributed and the 200 attendees were challenged to commit to walking on a regular basis with a "buddy".

DHSS participated on Safe Routes to School Task Force and prepared the annual notice to school nurses on Walk to School Week, in cooperation with the Blaustein School and the Diabetes Association. Lastly, in cooperation with certified bicycle engineers, bike safety education programs were offered to New Jersey youth, ages 10-14, in ten communities.

The three CPHA grantees that are addressing nutrition and physical activity with adolescents are following up in the spring of 2005 with pedometer projects that were piloted in the spring of 2004. A total of approximately 300 youth are targeted for this initiative. In addition, there are 3 school-based initiatives that were approved for pedometer mini-grants that will be implemented in the spring of 2005 with a total of approximately 650 youth.

The Osteoporosis Awareness and Education Act became law in 1997 but does not include a state appropriation. Osteoporosis activities are coordinated with the Division of Senior Affairs, in consultation with the Interagency Council on Osteoporosis (ICO). Activities during this grant year included reactivating the education sub-committee of the ICO to address osteoporosis prevention in youth; and, revising the KidStrong (Inside & Out) curriculum, evaluating its use as both an osteoporosis and obesity prevention strategy and developing a marketing plan for KidStrong as well as for the follow-up curriculum, Jump Start Your Bones.

As a key stakeholder of Action for Healthy Kids (AFHK), DHSS is collaborating in three "Super Saturday" regional events that are scheduled for spring 2005. A total of 1000 families and children are expected to attend and participate in activities that will focus on healthy foods, fun and physical activity.

DHSS has supported the Department of Agriculture's regulatory policy that addresses the nutritional standards of foods sold in New Jersey public schools. Public comment on the proposed policy ended January 2005.

c. Plan for the Coming Year

The NJCPFS will hold a statewide conference in April 2006 aimed at increasing physical activity throughout New Jersey. In addition, the Council will exhibit at statewide conferences to promote, motivate and educate NJ citizens on opportunities for pursuing a healthful lifestyle. A Get Fit New Jersey resource book, that will target inactive New Jersey adults, will be published and marketed. Finally, data collected on the Council's and Get Fit New Jersey web sites will be used to modify the sites as needed.

A New Jersey state department work group is expected to convene to discuss programming and potential overlap as well as joint funding of projects, i.e. bike safety program for youth, walking school bus, "walkable communities" workshops throughout New Jersey.

DHSS will continue to collaborate on the New Jersey Action for Healthy Kids, Healthy Choices to promote healthy nutrition and physical activity for New Jersey youth. Mini-grants will be offered to communities and schools to implement pedometer projects with youth.

State Performance Measure 7: *The percentage of children with birth defects who are appropriately reported to the New Jersey Birth Defects Registry.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	86	86	87
Annual Indicator	89.2	85.1	84.2	86.6	
Numerator	1217	1190	1186	1289	
Denominator	1365	1398	1408	1488	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87	88	88	89	90

Notes - 2004

No 2004 data is currently available. Hospital medical chart audits are currently on going for 2004 and will not be complete until December 2005.

a. Last Year's Accomplishments

State Performance Measure #7, the percentage of children with birth defects who are appropriately reported to the NJ Birth Defects Registry, was chosen to improve the quality of the Birth Defects Registry. The Birth Defects Registry has been an invaluable tool for birth defects surveillance, needs assessment, service planning and research. New Jersey has the oldest requirement in the nation for the reporting of children with birth defects. Beginning in 1928, New Jersey implemented reporting for children with orthopedic conditions. Since 1985, New Jersey has maintained a population-based Birth Defects Registry of children with all defects. This Registry supports the surveillance and service functions of CSHCN and children. Keeping the information as up-to-date and accurate as possible is critical for a population-based registry. Recently, the SCHS Registry received a five-year cooperative agreement from CDC. Funding from this project will enable the staff to develop a web-based data reporting and tracking system.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Annual Audits				**X**
2. Collaboration of 1 of 8 National Centers for Birth Defects Research				

and Prevention Quarterly reports to hospitals				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Annual audits performed by the SCHEIS staff are necessary to identify children with birth defects that would otherwise not be entered into the Registry. The audits performed at every maternity hospital and facility with pediatric beds also provide an opportunity to provide reporting performance back to the individual facilities. While birth defects affect 3-5% of all newborns and are a leading cause of infant mortality, the cause of 67% of birth defects is unknown. Improving the infrastructure and quality of surveillance data is a prerequisite for developing better programs and advancing research toward prevention. Data from the most recent audit shows that hospitals reported 86% of newborns having birth defects.

c. Plan for the Coming Year

With the receipt of a new surveillance cooperative agreement from CDC, the registry is seeking to improve the electronic surveillance system and will develop an electronic linkage with the SCHS Case Management Units. This will enable the staff from the Registry to track the services received by children with birth defects.

State Performance Measure 8: *The percentage of completed Birth Defects Study interviews.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	76	72	74		
Annual Indicator	76.5	72.2	72.4	72.4	
Numerator	453	460	398	398	
Denominator	592	637	550	550	
Is the Data Provisional or Final?				Provisional	
	2005	**2006**	**2007**	**2008**	**2009**
Annual					

Performance Objective					

Notes - 2003

New Jersey will not be participating in the National Birth Defects Study for children born after September 30, 2002. State Performance Measure will be dropped for 2005.
Data for 2002 entered into 2003 as required.

Notes - 2004

New Jersey will not be participating in the National Birth Defects Study for children born after September 30, 2002. State Performance Measure will be dropped for 2005.

a. Last Year's Accomplishments

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. New Jersey no longer participates in the Birth Defects Study. This state performance measure is inactivate in 2003 and 2004.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 9: *The percentage of HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	70	71	71	72	73
Annual Indicator	77.8	71.7	68.1	62.0	66.2

Numerator	207	157	147	114	104
Denominator	266	219	216	184	157
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	74	75	76	77	77

Notes - 2002

Notes - 2004

Numerator and denominator counts are provisional for 2004.

a. Last Year's Accomplishments

The percentage of HIV exposed newborns receiving appropriate antiviral treatment, was selected to focus efforts on reducing the perinatal transmission of HIV. Studies have demonstrated the dramatic reduction of perinatal transmission of HIV through the use of AZT. Accurately monitoring the identification and early management of pregnant women and at-risk infants should have a significant impact on reducing the perinatal transmission of HIV.

Early identification and AZT treatment of pregnant women identified as HIV infected appears to be reducing perinatal transmission to newborns. In looking at the number of reported cases of HIV/AIDS born in New Jersey, the number of infected cases dropped from 71 in 1993 to 5 in 2003. Each of New Jersey's seven Ryan White Title IV Family Centered HIV Care Network Centers has a dedicated perinatal care coordinator who is responsible for targeting outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age. Pregnant women identified as HIV positive are referred to specialty clinics within the network. AZT treatment is provided during pregnancy, delivery and to newborns according to the CDC protocol. All newborns are referred and managed within the network. Co-located mother-child or family clinics have been established in each site to facilitate long term maintenance of mother and child in care.

Data from the 2003 Survey of Child Bearing Women (SCBW) indicated that 84% of the mothers/newborns received AZT at the time of labor/delivery. This is a marked increase from 13% in 1994, the first year SCBW specimens were tested for AZT. With improvements in data collection and increased outreach and referral, the percentage of perinatally HIV exposed newborns appropriately treated with antiretroviral therapy should continue to increase. In conjunction with the Division of HIV/AIDS Services, the Network established a Perinatal HIV Advisory Committee in 2000 to develop a statewide policy for rapid testing and short course therapy to reduce the risk of perinatal HIV transmission in women who present in labor with an unknown HIV serostatus. Committee representation included Family Health Services MCH and SCHEIS staff, MCH consortia, OB and pediatric providers, Medicaid, and Ryan White Title IV Executive staff. In 2001 the Standard of Care for Women Who Present in Labor with Unknown HIV Sero status was developed. The intent of the Standard of Care is to provide HIV counseling and voluntary rapid or expedited testing of mothers in labor or delivery, or newborns in nursery units, if there is no documentation of prior HIV testing. Maternal and/or newborn antiviral therapy will be offered if the test is reactive. A hospital policy survey designed to assess the institution's ability to comply with the Standard of Care will be implemented in 2005.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

	Pyramid Level of

Activities	Service			
	DHC	ES	PBS	IB
1. Ongoing outreach and education targeting pregnant women		X		X
2. Ongoing collaboration with Division of AIDS Prevention and Control				X
3. Perinatal HIV Advisory Committee involvement Improved outreach & early identification by New Jersey				X
4. Perinatal HIV Advisory Committee				X
5. Collaboration with AIDS Learning Lab team members to conduct a web based survey tool to be distributed to all hospitals providing obstetrical services to assess potential gaps in compliance with Standard of Care for Women who present in Labor with Un				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

NJDHSS engaged the National Pediatric and Family HIV Resource Center to develop and implement a statewide Train-the-Trainer program. This program, directed to hospital OB nurse managers and educators, was designed to assist in staff training and policy development for the use of rapid testing and HIV counseling.

c. Plan for the Coming Year

The seven Ryan White Title IV Family Centered HIV Care Network Centers in New Jersey will continue in the coming year to target outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age.

In 2005, in collaboration with Title V, the NJ Hospital Association, the NJ AIDS Education and Training Center, the Division of Addiction Services, the Division of HIV/AIDS Services, and consumers, the Title IV program has implemented three projects designed to further reduce the perinatal transmission of HIV. An educational postcard message campaign is being implemented to reach pregnant women who are not engaged in medical care. A pilot retrospective medical chart review is being conducted in one MCH consortium to assess for missed opportunities, and a web-based survey of all NJ hospitals offering obstetrical care is being conducted to assess the availability of rapid HIV counseling and testing in the labor and delivery room.

State Performance Measure 10: *The percentage of communities receiving Community Partnership for Healthy Adolescent grants who have developed an adolescent health plan for their communities.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	10	10	9	8	8
Denominator	10	10	9	8	8
Is the Data Provisional or Final?				Final	
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2004

This State Performance Measure will be modified in the future.

a. Last Year's Accomplishments

The NJDHSS funds 8 Community Partnerships for Healthy Adolescents (CPHA) in 7 NJ counties in order that local health departments, community-based organizations, schools, and health care providers to collaborate in meeting State Performance Measure # 9. These youth-serving stakeholders coordinate programs and activities that reduce risk-taking behaviors and promote healthy behaviors among adolescents. The needs assessment that prioritizes the adolescent health issues in that community was updated, as was the Adolescent Health Plan.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Funding of Community Partnerships for Healthy Adolescents				**X**
2. Development of local needs assessment				**X**
3. Coordination of and collaboration with local health departments, community-based organizations, schools, and health care providers				**X**
4. Development of an Adolescent Health Plan to address priority adolescent health issues				**X**
5. Collaboration with Office of Local Health's Community Health Partnerships				**X**
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DHSS Child Adolescent Health Program currently funds 8 CPHA in 7 counties. Each Partnership has identified two priority adolescent health issues in their community. Of the eight, seven Partnerships have developed an Adolescent Health Plan to address injury and violence; three address nutrition and physical activity; three address sexual behaviors including unintended pregnancy and sexually transmitted infections and HIV; two address substance use

and abuse. Programs and interventions implemented by the Partnerships incorporate positive youth development and utilize "best practices" or "model" programs. Approximately 22,000 adolescents, 10-17 years old, are served annually through Partnership activities.

Several challenges have been identified as impacting the success of a community partnership. These include: maintaining the support and involvement of community stakeholders; the adequacy (and effective use) of financial and non-financial resources to comprehensively address the needs of youth; working collaboratively and setting aside ‘turf" issues; and, leadership abilities, communication and management capacity.

The use of a consultant, with expertise in partnership development, has been encouraged and supported to provide the Partnerships with the one-to-one technical assistance. In addition, the Partnerships are currently in the process of completing a Partnership Self-Assessment Tool available, on-line, through the Center for the Advancement of Collaborative Strategies in Health, New York Academy of Medicine. Upon completion of the Tool, the Partnership will receive a report of findings that will provide a score on key areas of collaboration, identify corrective actions needed to build a stronger collaborative and provide ideas for "next steps".

The NJDHSS funded the 2nd Annual Suicide Prevention Conference entitled, "Critical Issues in Youth Suicide" was held on May 6, 2004. In the fall of 2004, the Adolescent Health Coordinator, a representative from the Office of Local Health and the Director of Cancer Control and Prevention met to discuss county-level collaboration and coordination of activities to address the needs of adolescents.

c. Plan for the Coming Year

A staff representative from the Office of Local Health will be scheduled to attend a quarterly CPHA meeting to discuss the Community Health Partnerships, provide contact information and encourage county-level collaboration. DHSS will continue to support the development of community-based, adolescent focused partnerships to coordinate and implement activities and initiatives in a comprehensive manner to address the adolescent issues identified for a specific community. The CPHA will complete the Partnership Self Assessment Tool annually.

State Performance Measure 11: *The percentage implementation of activities from the state pediatric asthma plan.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	25	50	75	80	85
Annual Indicator	50	50	75	75	
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	

	2005	2006	2007	2008	2009
Annual Performance Objective	90	95	100	100	

Notes - 2003

A manual indicator has been reported rather than a numerator and denominator.

Notes - 2004

This performance measure is being inactivated for 2005.

a. Last Year's Accomplishments

Asthma has been identified as the most common chronic disease in children. In New Jersey in 2001, there were 5,492 hospitalizations and 8 deaths, among children 1 to 18 where asthma was the primary diagnosis. Hospitalization rates for asthma in the population under age 5 increased by nearly 12% between 1985 and 1999, while it decreased by 30% for children age 5-19 in the same period. Black non-Hispanic and Hispanic New Jersey residents are more likely to die or be hospitalized with asthma than white non-Hispanic residents. In the Special Child Health Services Registry, asthma is a condition for which voluntary registration is accepted, but less than 3,000 children are currently registered. A federal CDC grant, awarded in August 2000, is supporting the development of an asthma surveillance system for New Jersey. These funds enabled the hiring of a full-time asthma epidemiologist, in the MCH Epidemiology Program. Surveillance projects have included the completion of an annual Asthma Surveillance Report, an investigation of the impact of readmissions on pediatric asthma hospital admission rates, and an investigation of the association of aeroallergens and pediatric asthma hospitalizations. Strategic plans have been produced by the Interdepartmental Working Group on Asthma and the Pediatric Asthma Coalition of New Jersey. Based on these plans, the DHSS was able to obtain an increase in CDC funding to support asthma activities in New Jersey.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This state performance measure is inactive in 2005.				
2. Pediatric Adult Asthma Coalition on New Jersey				X
3. Asthma Surveillance				X
4. Special Child Health Services Case Management		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Staff from the Chronic Disease Program in SCA/EIS and the Child and Adolescent Health Program in MCCH have been participating in activities to coordinate and improve services for children with asthma (SPM #10), including issues of access. In 2002, the DHSS formed an Interdepartmental Working Group on Asthma. With the participation of staff from the Departments of Education, Human Services, and Environmental Protection, the working group

prepared a strategic plan for the activities of New Jersey State Government in addressing asthma.

Staff have assisted the American Lung Association of New Jersey and the New Jersey Thoracic Society in creating a statewide Pediatric Asthma Coalition of New Jersey (PAC/NJ). PAC/NJ, with more than 100 participating organizations and individuals, has developed a strategic plan for addressing asthma in children in the state. Task Forces have been formed to address each of the five goals of the plan. These Task Forces have produced a number of significant products, including a model Asthma Action Plan, a Diagnostic Worksheet for physicians, and a teleconference training for school nurses and school classroom staff.

In 2003, the activities of the Coalition expanded to address asthma in adults as well as children. As a result of this, the Coalition's name was changed to the Pediatric/Adult Asthma Coalition of New Jersey. The Coalition developed a new strategic plan, the "Pathway to Asthma Control in New Jersey", incorporating objectives and activities addressing both children and adults.

c. Plan for the Coming Year

The Pediatric /Adult Asthma Coalition of New Jersey (PAC/NJ) has developed a Strategic Plan to address asthma in New Jersey, and has formed six task forces to develop and implement activities to achieve the objectives of the Plan. DHHS staff will continue to participate on the Steering Committee of the Coalition, as well as on the School, Child Care, Education, and Health Insurance task forces.

The Interdepartmental Working Group on Asthma has also prepared a strategic plan to reduce pediatric asthma hospitalizations. A priority for the coming year is to complete development of a website for asthma information and education that will incorporate linkages to State and national resources.

E. OTHER PROGRAM ACTIVITIES

State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance measures outlined above, separate description may be necessary. Any activity not discussed within the priority needs and the performance measurement sections should be described here. These program activities often make significant contributions to the health and well-being of mothers and infants, children, and children with special health care needs within each State. Without these on-going program activities, the MCH population groups would not benefit from the full array of services available to them in some States. Each State has the opportunity to present these other activities in this section of the Application/Annual Report.

During the grant Year 2003-04, the Family Health Line received and assisted 12,020 calls, and made 13,763 referrals. The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The program coordinates quarterly staff trainings for the agency with an emphasis on current family health initiatives. In Year 2004, the trainings covered the Federally Qualified Health Center (FQHC) Project, The Governor's Mammography Campaign, the Lead Initiative, Diabetes Prevention and Prematurity/Folic Acid topics. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking.

F. TECHNICAL ASSISTANCE

The technical assistance needs of the State are reported on Form 15 and will likely be updated after submission of the MCH Blcok Grant Annual Report/Application.

V. BUDGET NARRATIVE

A. EXPENDITURES

Annual expenditures are summarized in Forms 2 -- 5 and below. The State Title V Programs Budget and Expenditures by Types of Service, parallels the pyramid shown in Figure 3, which organizes Maternal Child Health Services hierarchically from direct health care services through infrastructure building.

B. BUDGET

New Jersey has maintained and increased commitment of State funding support for maternal and child health activities. Since 1989, maintenance of effort has included State appropriations for children with special health care needs and support for population based outreach and education for pregnant women and their infants to name a few.

State appropriations support a number of maternal and child health programs. In the State fiscal year 2005 budget there have been a few proposed increases in State support. Most programs serving children and families and children with special health care needs and their families have remained level. There is continued commitment on the part of the State to support to the best of its ability services to the most vulnerable populations. Since the State budget will not be finalized until June 30, 2005, the following are the proposed funding levels for programs and services for FFY 2005 that reach maternal and child health populations in New Jersey:

Birth Defects Registry $ 531,000
Cleft lip and palate projects $ 651,000
Family Planning Services $4,767,000
Infant mortality reduction including a new project focused $2,205,822
on reduction of black infant mortality
Sudden Infant Death Syndrome $ 197,000
Newborn screening (revenue) $3,306,000
Postpartum Depression education $2,500,000
Postpartum Depression screening and referral $2,000,000
Early intervention for developmental delay/disabilities $59,965,000
Childhood lead poisoning prevention $ 883,000
Hemophilia services $1,105,000
Catastrophic illness in children relief fund $ 1,606,877
Handicapped children's fund, which is used to support $ 2,252,000
subspecialty care and case management services
Fetal Alcohol Syndrome $ 570,000
MCH Services $ 5,448,000
Lead Testing Kits for pregnant women $1,000,000
Council Physical Fitness and Sports $ 50,000
Tourettes Syndrome $1,250,000

Federally supported programs included in our federal state partnership for maternal and child health for FFY 2004 are as follows:

From the Centers for Disease Control and Prevention:
Childhood Lead Poisoning Prevention $ 1,088,000
Preventive Health and Health Services Block Grant $ 557,209
Asthma Surveillance $ 350,000
Early Hearing Detection and Intervention $ $144,000
PRAMS $ 149,548

From the Maternal and Child Health Bureau
State System Development Initiative $ 132,836

Abstinence Education $ 914,945
Mortality Review Coordination $ 72,000
Universal Newborn Hearing Screening $ 220,000
Healthy Start $ 500,000

From Other Federal Sources
Ryan White Pediatric AIDS $ 2,283,000
Family Planning $ 2,895,000
Primary Care Cooperative Agreement $ 215,737
Social Service Block Grant $ 1,922,000
US Dept of Education- Part C-Early Intervention $11,928,000
USDA -- WIC Administrative $23,885,700

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. State appropriations have included cost of living increases that are passed on to the service providers. New Jersey has undertaken several new or expanded initiatives over the past few years, which may in some cases, resulted in slight variations in allocations or expenditures. The annual Title V budget is summarized below. The following federal and state programs are targeted to meet performance measures and goals in the areas of maternal and child health for Year 2005 proposed or projected (the funding sources listed is not all inclusive):

Reproductive and Perinatal Health Services - State:
Fetal Alcohol Syndrome $ 450,000
Healthy Mothers / Healthy Babies $ 1,856,159
Black Infant Mortality Reduction $ 500,000
SIDS Resource and Counseling $ 185,000
Lead Dust Wipe Kits $ 1,000,000

Reproductive and Perinatal Health Services -- Federal:
Healthy Start -- East Orange $ 500,000
Child and Adolescent Health - State:
Childhood lead poisoning prevention activities $ 795,000
Lead Testing Kits $2,000,000
Reproductive Health Family Planning $4,300,000

Child and Adolescent Health -- Federal:
CDC Childhood Lead Poisoning Prevention $ 1,105,400
State System Development Initiative $ 737,598
Preventive Health and Health Services Block Grant $ 692,603
Abstinence Education $ 843,000

Federal-State MCH Block Grant Partnership Budgeted FY 2003
a. Pregnant Women $ 4,901,766
b. Infants < 1 year old $ 4,636,945
c. Children 1 to 22 years old $ 9,891,684
d. CSHCN $10,953,277
f. Administration $ 1,011,000

SUB-TOTAL $ 31,394,672

II. Other Federal MCH Related Funds

a. WIC
b. SPRANS
c. EMSC

d. AIDS $ 2,072,878
e. Healthy Start $ 500,000
f. CISS $
g. CDC $ 3,099,467
h. Education $
Abstinence Education $ 843,000
SSDI $ 132,836
k. Social Security BG $ 1,922,000
l. Family Planning $ 3,121,766
m. Early Intervention $ 10,193,673
n. all others $ 971,013

SUB-TOTAL $ 22,856,633

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.